MAKING SPACE FOR YOUNG PEOPLE’S VOICES: ADOLESCENT AND CLINICIAN PERSPECTIVES ON CLINICAL ENCOUNTERS FOR SEXUAL HEALTH

by

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Abstract

Clinical care that meets young people’s needs can play a role in addressing serious inequities in terms of their sexual health. In considering the poor uptake of sexual health care and the potential disconnect between the care young people want and what they receive, this study makes a case for examining social context as a key influence in clinical encounters about sexual health. The goal of this study was to understand clinical encounters focused on promoting the sexual health of young people and the power dynamics embedded in social contexts that shape these encounters. Individual interviews and focus groups were conducted in Victoria, British Columbia, with 50 young people, aged 16 to 19, and with 22 clinicians who work with youth. The transcribed data were analyzed using critical techniques and intersectional analysis. Results indicated three dimensions of social context that shaped clinical encounters about sexual health, presenting obstacles to change: ideologies, structural barriers, and the influence of space and place. Three key discrepancies were also revealed between young people’s self-described needs and the clinical encounters they actually received. First, contrary to clinicians’ agendas focused on managing risk, young people favoured a more comprehensive approach that would accept their sexuality and indicate that positive sexuality mattered. Second, in contrast to the assumption that young people wanted clinicians as experts, young people described wanting acceptance but experiencing judgment. Third, instead of the gender-based approaches to managing sexual risks described by clinicians, young people described gender-specific strategies for managing the vulnerability of the clinical encounter. Young men often described resisting and avoiding care, or reducing exposure to vulnerability by “getting in and getting out” of the
exam room. Young women sought personalized and warm relationships with clinicians. Young people’s perspectives highlighted their need to discuss sexuality with the understanding that acceptance and support are required in navigating both the dangers and pleasures of sexual activity. Sexual health care could be improved by promoting sex-positive approaches that take into account intersections of gender, sexuality, and space and place and by addressing the structural factors that limit clinical care.
Preface

This dissertation is an original intellectual product of the author, Leslie Kim Daly. The fieldwork reported in Chapters 3-6 was covered by UBC Ethics Certificate H10-02835.
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Dedicated

to the memory of my mother, Leslie,

and my father, Sheldon.
Chapter 1: Situating The Study

Statement of the Problem

When the World Health Organization convened an international technical consultation on sexual health in 2002, experts on sexual health agreed that “programmes and services aimed at addressing sexuality and promoting sexual health can and must be based on fundamental values and principles grounded in human rights” (World Health Organization, 2006). According to the WHO, therefore, people of all ages have a right to the highest attainable standard of sexual health, including health care that meets their needs. However, evidence suggests that in terms of sexual health status for young people serious inequities remain.

While research indicates that the sexual health status of young people in Canada and the US is better than it has been in previous generations, there is still significant room for improvement (American Sexual Health Association, 2014; Canadian Federation for Sexual Health, 2007). Across North America, many young women and men experience significant health and social problems related to sexually transmitted infections (STIs) and early unintended pregnancies. Young Canadians have the highest reported rates of STIs (Public Health Agency of Canada, 2013) and the majority of chlamydia and gonorrhea cases continues be reported among younger Canadians (Public Health Agency of Canada, 2012). For example, in 2012, in British Columbia the rates of chlamydia infection were highest among young women (1,433.0 per 100,000) 20 to 24 years old, followed by young women 15 to 19 years old (351.9 per 100,000). Furthermore, over 15,000 young women in Canada aged 15 to 19 have an abortion each year, and it can reliably be assumed that the vast majority of these pregnancies were unintended (McKay, 2012). In the US, there is also evidence of inequities for young people in terms of their
sexual health status. Each day in the United States, 2,000 young people get pregnant, 10,000 acquire a sexually transmitted infection, and 33 contract HIV (American Sexual Health Association, 2014). Furthermore, young people are at highest risk of abuse by a dating partner (Department of Justice, 2006; Tutty, 2011). For example, in a survey of young people in Atlantic Canada (ages 12 to 18, N= 627) 62% of girls and 60% of boys had experienced some form of emotional violence, defined as threats, insults, and controlling behaviour in dating relationships (Sears & Byers, 2010). In British Columbia, 6% of young people (grades 7–12) who had been in a dating relationship had been a victim of physical violence within the relationship (Smith et al., 2014). These statistics reflect a higher burden of sexual health concerns among young people as a group compared to adults.

In Canada, further inequities become apparent when young people with the poorest sexual health outcomes live in regions where families have lower income and weaker connections to paid employment and in areas with a greater concentration of First Nations population (Maticka-Tyndale, 2008). In these regions, geographic, economic, and social forces intersect, increasing the likelihood that young people will experience unintended early pregnancies and sexual violence and will be more vulnerable to sexually transmitted infections (Maticka-Tyndale, 2008). It is likely that some of these same forces play a role in influencing the sexual health status of young people living on the street in Canada; these young people have higher rates of STIs than young people in the overall population (Public Health Agency of Canada, 2006).

Clinical care that meets young people’s needs could play a key role in addressing these health inequities. Young people trust health professionals and consider primary care providers to be an important source of information on matters pertaining to sexual health (Frappier et al.,
2008). However, young people in Canada and the US face significant barriers in accessing clinical care, which represents further health inequities for this age group, especially with respect to sexual health (Solberg, Nordin, Bryant, Hazen Kristensen, & Maloney, 2009). Primary care clinicians exhibit low levels of involvement in the challenging task of communicating sexual health information to their clients (Burstein, 2003; Flicker et al., 2009; Irwin, 2005; Marcell & Ellen, 2012; Montaño, Phillips, Kasprzyk, & Greek, 2008; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006), especially to young men (Marcell & Ellen, 2012). In one Canadian study conducted in Toronto, Ontario, with young people aged 13 to 19 years (N=1216) 83% reported that they had never visited a clinician for any sexual health care-related reason (Flicker et al., 2009). In a US study using data from the Medical Expenditure Panel Survey (ages 10 to 17; N=8464) only 38% of young people had a preventive care visit in the last year (Irwin, Adams, Park, & Newacheck, 2009). Among those who received visits only 40% had time alone with their clinician, a proxy for confidential services such as preventive guidance about sexual health (Irwin et al., 2009). A more recent study in the US showed that when clinicians did talk to young people about sex these conversations lasted less than half a minute (American Sexual Health Association, 2014).

Though young people’s voices are not often included in the literature about clinical sexual health services, when their perspectives have been included some research findings suggest a disconnect between the clinical encounter they want and what they receive. For example, in the study in Toronto, Ontario young people (ages 13 to 19, N=1216) accessing sexual health services indicated that they were generally unhappy with the care they received (Flicker et al., 2009). In another Canadian study, from rural British Columbia, young people (ages 15 to 24, N=45) suggested that changes should be made to existing sexual health services
to make those services more positive for young people (Soon, Shoveller, Kelm, Johnson, & Hanlon, 2009). Some of the changes these young people suggested included training for clinicians to increase their ability to “connect” with young people, using a more casual communication approach that would minimize embarrassment, and to provide more personal attention and time to encourage discussion (Soon et al., 2009).

Given the considerable room for improvement in the overall sexual health of young people, significant clinical and research attention has focused on negative constructions of young people’s sexuality—the problems and risks associated with young people’s sexual behaviour (Shoveller & Johnson, 2006). In keeping with this emphasis on problems, and specifically on avoiding disease and pregnancy, health research has focused primarily on biomedical and epidemiological approaches to sexual behaviour (Fortenberry, 2009). This epidemiological tradition has often left out the personal and social contexts of young people’s sexual behaviour, treating such contexts as ancillary to the “disease” afflicting the individual young person, rather than as interrelated factors central to sexual health care. Conversely, sociological research has demonstrated the negative effects of sexism, racism, heterosexism, and poverty on young people’s sexual health ((Bay-Cheng, 2003; Fine & McClelland, 2006)). Between the two approaches are significant gaps in the clinical literature.

In considering the poor uptake of sexual health care and the potential disconnect between the care young people want and what they receive, this study makes a case for examining social context seriously, as a key influence in clinical encounters about sexual health. At the theoretical level, disciplinary orientations in nursing and medicine have positioned the particular practices that make up clinical encounters about sexual health as driven primarily by the thoughts and attitudes of individual participants. As a result, fewer health research studies have examined the
social context of the clinical encounter. Without a solid understanding of the context within which young people navigate clinical encounters whose purpose is to promote sexual health, clinicians cannot begin to develop best practices relevant to young people’s needs. Therefore, this study analyzes not only the diverse perspectives of both young people and clinicians in clinical encounters about sexual health but the social context that shapes these encounters. This knowledge is needed in order to promote changes to practice, research, and policy that can reduce the sexual health inequities for young people, who bear some of the greatest burdens of poor sexual health.

**Study Purpose and Objectives**

The purpose of this qualitative descriptive study was to more fully understand clinical encounters focused on promoting the sexual health of young people and the power dynamics embedded in social contexts that shape these encounters. Situated within clinic sites in Victoria, British Columbia, my study drew upon particular theoretical aspects of intersectionality to help inform the research design and analysis. Grounded in the reality that young people’s voices have been overlooked in research and that aspects of identity such as sexuality, age, and gender cannot be understood in isolation from each other, the theoretical tool of intersectionality is essential in examining how social context shapes clinical encounters about sexual health. From the initial conceptualization of this study, my goal has been to generate insights for practice in an attempt to improve sexual health opportunities for young people.

My field research was initially guided by these questions:

1) What are young people’s perspectives on clinical encounters that are intended to promote sexual health? What are meaningful elements of their experience that should be addressed?
2) What are clinicians’ perspectives on clinical encounters that are intended to promote young people’s sexual health? What do they consider to be meaningful elements of these encounters?

3) What is the discrepancy between young people’s perceived needs in the clinical encounter and the clinical encounter that they actually receive?

Once immersed in the field, with my understanding of the issues enriched and augmented by my experience on the ground, I developed another question that guided the work and reflected my goal to improve young people’s opportunities for sexual health. In keeping with this priority, my central research question became simpler, yet more theoretically informed: How does social context shape clinical encounters about sexual health for young people and thus influence their opportunities for health?

At this point, I made the distinction between clinical encounters based on individual thoughts and actions and clinical encounters composed of a “collective social practice” (Poland et al., 2006, p. 60); my emphasis was on the latter. Clinical encounters are routine yet decidedly social events. Clinical encounters about sexual health are generated at intersections of social structure (institutional practices that organize care, resources, ideologies) and agency (individual actions and identities), and are made manifest in specific social locations and spaces.

In exploring the social context of clinical encounters I drew on Poland and colleagues’ identification of the multiple dimensions of social context (2005). In the case of clinical encounters, these dimensions could include the following: (1) power relations that shape the encounter; (2) physicality, or considering bodily practices and the encounter as sometimes including physical events; (3, 4) clinician practices or client practices embedded in collective patterns of health-related behaviour and linked to identity formation. Behaviours and activities in
the clinical encounter may vary depending on what is economically and socially appropriate when a social identity is constructed or maintained that expresses or signals difference among and between social groups; (5) desire and pleasure associated with sexuality, but also the ambivalent relationship that sexual health promotion has had with young people’s sexual desire; and (6) space/place as a condition and consequence the activities of the encounter.

I had four specific research objectives:

1) to critically analyze clinical encounters focused on promoting the sexual health of young people and the social context that shape these encounters;

2) to bring to light young people’s and clinicians’ voices that are not usually heard;

3) to analyze the interrelationships between different aspects of social identities, as well as place and space, to understand how these influence young people’s opportunities for health;

4) to generate recommendations to inform clinical practice, education, and research to optimize young people’s opportunities for sexual health.

Background to the Study

Ontology and epistemology.

Since the ontological and epistemological positions of the research affects every stage of the research process, clarifying these positions is an essential part of contextualizing the study. My qualitative inquiry was consistent with realist ontology “where realities exist outside of the mind” (Crotty, 1998, p. 10). This ontological stance was joined with a constructionist epistemology where meaning and knowledge are mediated by power relations, created in peoples’ engagement with the realities of their world, from their particular position in the social order. Thinking about how knowledge is constructed, from the situated perspectives of young
people and clinicians, directs the researcher’s attention to dimensions of difference that intersect and are inseparable in the real world: gender, age, and sexuality, for example.

By looking critically at clinical encounters about sexual health through these perspectives, the researcher enlists multiple contested positions in the investigation of power relations. These multiple positions focus attention on power, acknowledging how individual knowledge is embedded in the larger realm of sociopolitical complexities that advantage some people and disadvantage others in specific ways (Doane & Varcoe, 2015). Knowledge, therefore, “cannot be separated from the knower because even ‘facts’ are created and interpreted by people” (Doane & Varcoe, 2015, p. 232). A research approach informed by critical theory reveals how social processes, power relations and place (Thomas, 1993) all work together to shape clinicians’, young people’s and my own perspectives.

Constructing knowledge is the task of the researcher, but the researcher also already possesses knowledge. I must therefore ask what knowledge I bring to the clinical encounter and whose values might dominate in shaping the way information is used and acquired in the research. In this study, if my knowledge, clinicians’ knowledge and young people’s knowledge were all brought into play, it is the dynamics of power relations that arise during the research process that shape the production of knowledge about the research question. For example, when the perspectives of young people are included who are not typically considered in the production of knowledge about clinical practice, dominant discourses and practices begin to shift and relations of power, activated through knowledge production, begin to be disrupted (Hankivsky et al., 2012).
My social location and experiences.

In coming to this study I am informed by sixteen years of experience working with young people as a nurse, a clinical counsellor, and a researcher. In a situated research framework it is important that the researcher be reflexive about the ways in which their experiences and perspectives are contextualized. Because I want the particular perspectives I bring to the work to be transparent, I have included my own experiences and social locations that inspired, informed and biased my analyses and my processes of knowledge production.

I have worked with young people in many different settings, including in schools, on the street, and in urban youth clinic settings. My clinical experience has often been focused on sexual health, as well as the needs and issues of young people who find themselves outside of the mainstream, facing additional barriers to health such as homelessness, poverty, substance abuse, or issues around sexual orientation. In my past research on the health care needs of adolescent girls in dating relationships (Banister & Daly, 2006), I gained an understanding of young women’s perspectives on their sexual health, and more specifically, an understanding of health concerns about their dating relationships. I listened to many young women’s stories, noting the extent to which some had difficulty expressing and acting on their needs and desires within their dating relationships. Such difficulties make them vulnerable to substance misuse, social isolation, and individual and social acceptance of violence (Banister, Jakubec, & Stein, 2003). I came to more fully appreciate the ways in which sexual relationships could involve significant negative health outcomes for young people. Hearing these young women’s stories became a turning point for me as a clinician. I needed to develop a clinical approach that went beyond attempts to modify or eliminate sexual risk behaviours and would also address the complex social contexts that shape sexual health experiences.
I became keenly aware that my clinical talk, focused primarily on promoting healthier individual choices, assumed a level of agency that did not correspond with the reality of many adolescent lives. For example, in one young woman’s particular situation, if she believed sex without a condom was expected and would demonstrate her trust and thus maintain her dating relationship, then this might be what she would “choose.” When I realized some young women give up on safer sex in favour of a clear statement about the significance of their relationship, it no longer made sense to focus clinical conversations only on the particulars of condom application. If questions of personal agency and social context were so relevant to sexual behaviours, I concluded that my “safer sex” talk was useful and necessary, but inadequate. A singular focus on risk reduction addressed neither the real choices to be made in many young women’s sexual lives nor their developing sense of themselves in relationships.

My participation in research and clinical practice provided the opportunity to ask young women about desire and sexual pleasure in their lives, and I was surprised to discover a lack of clarity about pleasure and desire. When I asked a small group of 17-year-old women what words they might use to speak with their peers about their sexual desire, they stated, “I don’t know what we would call it [desire]—maybe getting it on?” followed with a warning: “You know, girls aren’t really supposed to talk about that.” Some younger women simply acknowledged that they had no words for desire. Then I asked individual young women about their experiences of sexual pleasure. Some could clearly articulate their experience of sexual pleasure, while others stated that pleasure was not part of their experience. Though all these young women were sexually active, many did not identify, voice, or validate their sexual desire. This “missing discourse of desire” (Fine, 1988, p. 29) left me examining my own preconceptions and searching for new ways to think about the meaning of my practice in sexual health. If sexual desire was
often not the primary motivator for sexual behaviour, I wondered what meaning I could discover when counselling people about safer ways to have sex. My clients told me that they sometimes engaged in sexual behaviour when they wanted to, but also when they felt compelled to do so, “for reasons other than their own sexual desire” (Fine & McClelland, 2006, p. 17). In my opinion, a clinician’s lack of critical conversation around these young women’s social context and the gendered politics of negotiating safer sex would probably not only be unhelpful, but would miss addressing important health concerns the women might have. I had often just focused on skill acquisition, demonstrating how to put on condoms. Instead, I wanted the education and counselling I offered to be more comprehensive and to address not just sexual risk reduction, but also the possibility of pleasure and agency in relationships.

Realizing the limitations of my risk reduction approach, I turned to the growing literature that uses an intersectional perspective on gender for an alternative analysis of adolescent sexuality. Reading this contributed to my understanding of the social and political contexts of sexual health in adolescence. I began to observe intersections of sexuality, gender, and class in clinical practice, and the impact these intersections might have for specific young people and their sexual development. With a new awareness of what I felt to be missing in my clinical approach, I found myself attempting to modify individual risk behaviours less and listening more. I had more serious conversations about the personal and social context of individual choices and the meanings young people derived from them. When I looked to the clinical practice literature, however, I found little to guide the clinician committed to establishing more comprehensive models of clinical communication.

One first step, therefore, in developing more responsive and comprehensive ways of talking about sex was to ask different groups of young people what they require in a clinical
encounter that moves beyond risk and instead attends to both a young person’s sexualities as well as the social contexts of sexual health. By critically analyzing clinical encounters about sexual health and the social contexts that shape these encounters, the current study represents an important foundation for informing clinical practice promoting sexual health.

**Young people’s rights related to sexual health.**

If, as the WHO report of 2006 states, sexual health is a basic human right, then all health care services aimed at addressing sexual health should be based on fundamental principles and values “grounded in human rights” (World Health Organization, 2006, p. 3). In keeping with this view, young people have a right to sexual health clinical encounters that aim to meet their needs (Flicker et al., 2009; Gahagan, Rehman, Barbour, & McWilliam, 2007). The Canadian Guidelines for Sexual Health Education recognize that the sexual rights of all persons should involve “the highest attainable standard of sexual health, including access to sexual and reproductive health care services” (Public Health Agency of Canada, 2008). I take the position that young people are experts about their bodies and their social context, so their needs and perspectives are an important foundation in designing clinical care (Flicker et al., 2009; Gahagan et al., 2007). The necessity to consult with young people regarding all matters that affect them, including sexual health needs, is supported by the provisions and principles of the United Nations Convention on the Rights of the Child (1989). Furthermore, the Canadian Guidelines for Sexual Health set out the need for clinical interventions that are comprehensive, skill-building, and accessible to the population for which they are intended, further reinforcing the need to listen to and respond carefully to their voices in developing clinical interventions for diverse groups of young people (Public Health Agency of Canada, 2008).
Sexual health education in Canada.

Though young people in Canada obtain information and support regarding sexual health from different sources, including family, friends, clinical and community services, and mass media, school-based education is still the primary venue (Gahagan et al., 2007). Therefore, some appreciation of the quantity and quality of sex education provided to students in schools in Canada is relevant to the discussion here. Studies in Canada suggest that school-based sexual health education is inadequate (Barrett, 1994; Cohen, Byers, & Sears, 2012; McCall & McKay, 2004; Ninomiya, 2010). Ninomiya, for example, reported a general absence of teacher training, outdated teaching resources, and limited awareness of sexual diversity among the student population in Newfoundland and Labrador schools. Cohen, Byers, and Sears found that Canadian teachers were not always willing to teach sexual health education, and their willingness varied depending on the topics. An earlier study found that many schools and school districts do not fully implement their sexual health curricula and lack resources and coordination to assure effective programming (McCall, Beazley, Doherty-Poirier, Lovato, & MacKinnon, 1999). This same study also revealed other challenges to effective education, such as a lack of instructional hours, insufficient learning materials, and some teachers’ avoidance of instruction on key concepts. Also, attempts to modernize the provincial sex health education curriculum to meet the current needs of young people have been met with resistance across the country (Agrell & Picard, 2010). For example, the province of Ontario postponed an update to their sexual education curriculum because of resistance from vocal parent groups, even though the planned changes were based on an extensive consultation process involving young people and other community groups and organizations (Agrell & Picard, 2010). Given the challenges in accessing quality school-based sexual health education, clinical services are an essential resource for young
people who may not receive any other sexual health education or who may receive inadequate information from other sources.

**Existing Knowledge of Clinical Encounters about Sexual Health**

Existing knowledge regarding clinical encounters about sexual health will be reviewed in the second chapter. However, a brief summary of key points about current knowledge helps to clarify areas for further investigation. Clinicians are uniquely positioned to offer sexual health counselling to their clients. However, many young people do not receive sexual health care during routine health care encounters, even though young people are interested and willing to discuss sexual health topics with clinicians (Irwin, Adams, Park, & Newacheck, 2009). For example, Canadian physicians completed sexual health assessments and routine screening for chlamydia for sexually active young women (Hardwick, McKay, & Ashem, 2007) at a frequency well below that recommended in the Canadian Guidelines on Sexually Transmitted Infections (Canadian Publications & Expert Working Group on Canadian Guidelines for Sexually Transmitted Infections, 2008). When asked about the likelihood of their recommending chlamydia testing for young women in different types of visits, over 90% of physicians said they would do so if the client asked, only half would do so in routine annual visits, and only 3% said they would do so in visits for other reasons (Hardwick et al., 2007).

In addition, there is little evidence about the most effective methods of discussing sexual health with young people (Shafii et al., 2014). Though some studies have examined young people’s general requirements for health care (Tylee, Haller, Graham, Churchill, & Sanci, 2007) and some specific characteristics of successful clinic-based intervention for STI prevention (Sales, Milhausen, & DiClemente, 2006), few studies have included young people’s or clinicians’ voices about clinical encounters about sexual health. However, when young people’s
perspectives have been included, research findings suggest a potential disconnect between the clinical care they want and what they receive. As another example, in a small qualitative study done in an urban center in the United States, young men perceived that clinicians delivered safe sex counselling in a superficial and impersonal manner (Rubin, McKee, Campos, & O’Sullivan, 2010). In order to increase the perceived relevance of care, these young men described the key role of positive clinician-client interactions and clinician demeanor and communication style (Rubin et al., 2010).

Biomedical approaches to sexual health dominating the clinical literature have helped to shape an orientation to research and practice that positions sexuality primarily as an individual level health behaviour. As a result, the social meaning of sexuality, as well as the social context of the clinical encounter, has not been studied well. Few studies focus on young people’s perspectives on client-clinician interactions, especially relating to sexual health communication (Shafii et al., 2014). Therefore, what sexuality means to young people in the context of clinical care is not well understood, nor are the complexities that arise in the clinical encounter at different intersections of social positioning. Not surprisingly, researchers have noted that social contexts, including power relations and desire and pleasure, have not often been well integrated into models of clinical care (Gahagan et al., 2007; Oliver, van der Meulen, Larkin, & Flicker, 2013).

**Significance of the Clinical Encounter and Its Social Context**

Why would the social context of the clinical encounter matter? The main reason is that failing to account for social differences may hamper effective research and practice. The burden of poor sexual health is unevenly distributed, especially among socially disadvantaged and marginalized young people, suggesting social processes at work that could be more fully
understood in the realm of clinical care. It has been frequently observed that clinicians cannot afford to be ill-informed about social processes influencing sexual behaviour or about what young people think and need in clinical encounters about sexual health (Aggleton & Campbell, 2000; Brindis, 2002; Gahagan et al., 2007; Maticka-Tyndale, 2008). Yet at the same time, sexual health practice as a field seems to exhibit ongoing difficulties in engaging with young people and in understanding young people’s diverse perspectives. Regrettably, young people’s voices and their participation are still largely absent from many clinical and research initiatives, including research conferences. Therefore, including and analyzing these perspectives to promote a greater understanding of clinical encounters and the social contexts that shape these encounters will help to enhance clinical practice and research.

A Glossary of Terms

When discussing issues pertaining to young people’s sexual health, it is important to be aware that some terms and concepts may have different meanings for diverse individuals and groups. I therefore discuss key concepts to clarify how certain terms are understood in this work.

Sexual health.

For the purposes of this study I have adopted the working definitions of sexual health and sexuality set out by the WHO’s technical consultation on sexual health in 2002. The WHO report (2006) goes beyond defining health as simply an absence of disease, and recognizes the complex nature of sexual health and of the psychosocial and structural factors that are part of sexual health. Sexual health is thus construed as a normative aspect of life. The Public Health Agency of Canada uses this same definition of sexual health in the Canadian Guidelines for Sexual Health Education:
Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach not only to sexuality and sexual relationships, but also to the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled. (World Health Organization, 2006, p. 5)

**Sexuality.**

According to the World Health Organization, sexuality is an essential aspect of being human, from the beginning to the end of life. It includes sex, sexual orientation, gendered identities and roles, eroticism, intimacy, pleasure, and reproduction. Sexuality encompasses fantasies, thoughts, beliefs, desires, values, attitudes, behaviours, relationships, roles, and practices. However, these dimensions are not always expressed or experienced, and they vary according to individual circumstances (World Health Organization, 2006). The World Health Organization explains that “sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors” (World Health Organization, 2006, p. 5).

**Risk.**

Risk is a concept that is understood and applied differently across different fields of knowledge. Therefore, depending on the discipline, the ontological and epistemological status of risk and how it is theorized varies (Lupton, 2013). In the context of this work, where I refer to a “risk-reduction” approach to sexual health promotion, risk is usually understood in a manner consistent with traditional risk-factor epidemiology. This particular way of understanding risk is
consistent with what Lupton describes as a “naïve realist” perspective, in which the nature of risk is taken for granted and is considered “real” and pre-existing in nature, so that the calculations produced in traditional epidemiological studies are then viewed as objective facts. However, as Lupton explains, in late modernity the noun “risk” and the adjective “risky” have become commonly used in everyday talk. Risk can also now simply refer to a danger or a potential harm. This “looser” concept of risk has also found its way into the literature in sexual health discourse among experts, as in this claim, for example: “more needs to be done to promote risk reduction within adolescent sexual activity” (Fantasia & Fontenot, 2011, p. 217). In this example, consistent with everyday understandings, risk “indicates only arm-waving in the direction of possible science” (Douglas, 1992, p. 24). Risk refers instead to danger, such as that which leads to negative sexual health outcomes—it has become a term that does not necessarily implicate calculable probabilities. This more colloquial, and much looser, understanding of risk always refers to the future, to a negative outcome that has not yet happened (Lupton, 2013).

Young people.

The term young people is used throughout this document and refers to individuals between the ages of 13 and 19, unless otherwise stated. I have employed this term because it emphasizes rights and personhood (Spencer, 2013). In contrast, the term adolescence, particularly in Canada and the United States, tends to be employed normatively, to refer to a stage of life cured only by the passage of time, leading to an allegedly responsible and stable adulthood (Spencer, 2013). In Australia and the United Kingdom the term adolescence is often avoided because of “its tendency to homogenize and pathologize all young people” (Spencer, 2013, p. x) and because of its potentially negative connotations. The term young people was
selected because it was also preferred over *adolescent*, a term that has been defined and theorized by adults, or *teenagers*, a more colloquial term.

**Organization of the Dissertation**

The remainder of this work is based upon the premise that clinical encounters about sexual health cannot be fully understood outside of the social context in which they emerge. The overarching aim of the work is therefore to understand how clinical encounters focused on promoting the sexual health of young people are shaped within the powers dynamics embedded in social contexts that influence opportunities for health. In Chapter 2 I review key areas of the literature related to the research. In Chapter 3 I describe the theoretical foundations of the research and the research design and methods employed. Chapter 4 is the first analytic chapter, focusing on the interrelationship between power and place in the different clinical settings where the research was conducted. In the fifth chapter I present an analytic discussion of the perspectives of clinicians on clinical encounters aimed at promoting sexual health. Chapter 6 is devoted to an analysis of young people’s perspectives. In the final chapter I consider the ways in which the study methods and findings can enhance research, clinical practice, and theoretical understandings of sexual health, with the goal of enhancing sexual health care for young people.
Chapter 2: Literature Review

In this chapter, I review six key areas of the literature that relate to the social context of clinical encounters about sexual health: 1) the social construction of young people and their sexuality; 2) current practices around sexual health education for young people in primary care settings; 3) clinic-based risk-reduction interventions to improve sexual health; 4) young people’s perspectives on sexual health education, counselling, and clinical care for sexual health; and finally, 5) gender and 6) risk as key ideas relating to the social context of the clinical encounter.

The Social Construction of Young People and Young People’s Sexuality

Ideology is part of the social context that shapes both the practices and the possibilities of clinical encounters about sexual health. Some critical social theory and even a few empirical studies have addressed ideas and expectations about young people and their sexuality that are relevant to the clinical encounter, situating those ideas and reasonings within scholarly knowledge.

The myth of adolescence.

Since its formulation in 1904 (Hall), the concept of adolescence has been thoroughly integrated into North American views about age, development, and cohort. Adolescence has been understood to refer to individuals who belong to a unique culture and social group (Brickell, 2013). Critical social theorists have also reflected on the prevailing characterization of adolescence as a time of trouble. In negative and stereotypical perceptions of adolescence, it is a time of emotional and behavioural disturbance (Bay-Cheng, 2003), a period of “sturm und drang” (storm and stress) that is assumed to be problematic in nature (Paiva, Ayres, & França,
In their examination of normative ways of presenting sexual health in clinical care and in sex education, Paiva, Ayres, and França suggested that studies of adolescence in the health sciences have often focused on the problems of young people attributed to social, intellectual, physical, or emotional immaturity. Vadeboncoeur, a sociocultural psychologist, described a prevailing view of young people as an “unfinished” product, occupying a wasteland between childhood and adulthood (Vadeboncoeur & Patel Stevens, 2005). Vadeboncoeur asserted that this dominant view controls and limits young people, “restricting their bodies” (p. 2), their relationships, and ultimately their life choices and possibilities. Similarly, Lesko, in her theoretical work on the social construction of adolescence, described a period of life that is assumed to be a time of crisis and transition, filled with rebellion, and ultimately “cured” by the passage of time when young people reach adulthood (2001). The belief that adolescence is a time of turbulence and trouble has been referred to as one of our dominant myths of adolescence (Buchanan & Hughes, 2009), and has become integrated into both popular culture and academic understandings of young people (Findlay & Frappier, 2008). Even now, some resources intended to be helpful to families and others working with young people place emphasis on negative characterizations, referring to people in their teen years as “brain-damaged” or “aliens” (Buchanan & Hughes, 2009).

In contrast to the negative themes described by critical social theorists, a minority of health researchers has challenged the discourse of turbulence and trouble in adolescence, identifying adolescent strengths, and some have even offered population-based evidence to support positive characterizations of young people. For example, recent population-based evidence from the BC Adolescent Health Survey, completed by almost 30,000 public school students, has shown that contrary to negative themes in the media and in some health care
literature, most young people in British Columbia are in good emotional and physical health, feel positively connected to their families, feel good about themselves, and engage in healthy behaviours, including avoiding alcohol and tobacco (Smith et al., 2014).

In another much smaller empirical study, Buchanan and Hughes (2009) showed how young people’s and mothers’ expectations for risk-taking and rebelliousness predicted increases in young people’s reported negative outcomes in relationships and behaviour. In their discussion, Buchanan and Hughes suggested that negative cultural stereotypes may create problems that may not otherwise have existed, identifying a small research base that is consistent with “the possibility of such self-fulfilling prophecies (p. 263).

Adolescent sex as risk and danger.

Given the prevailing characterization of adolescence as a time of trouble, critical social theorists and health researchers have established a strong link between the concept of young people and the concept of risk (Buchanan & Hughes, 2009; Shoveller, Johnson, Savoy, & Wia Pietersma, 2006), particularly between young people’s sexuality and risk (Bay-Cheng & Lewis, 2006; Bay-Cheng, Livingston, & Fava, 2011; Fallon, 2013; Schalet, 2004). Social theorists have described how many adults view adolescence as a time of heightened sexual risk-taking behaviour. Lesko observed how adolescence “has been centrally about sexuality and fear of sexuality” (Lesko, 2001, p. 13). In a similar vein, Ashcraft considered how dominant characterizations of young people’s sexuality have positioned young people as “the other” in contrast to adults. Adults, who might claim to usually being responsible for the consequences of their sexual activity, are compared to young people, who are deemed immature, irresponsible, and lacking control, and Ashcraft points out how such a comparison hides important similarities between adults and young people (Ashcraft, 2003). Additionally, the immaturity of young people
is often understood to preclude a sufficient appreciation for behavioural consequences, thus marking young people as vulnerable to sexual exploitation (Bay-Cheng, 2003).

Reflecting negative themes from these studies in social and cultural theory is Schalet’s empirical work in which she conducted in-depth interviews with 31 parents of young people. These interviews revealed that American parents describe young people’s sexuality as threatening, provoking discomfort, and even as “hostile to the family” (p. 89), threatening its integrity. In a similar vein, in examinations of young people’s sexuality through school-based education, Macleod (2009), Bay-Cheng (2003), and Allen (2007a) all found evidence that sexuality is presented almost exclusively in relation to its dangers and deficits. Shoveller and Johnson, in their review of psychological and social aspects of risk and youth sexual behaviour, suggested that sex-negative and youth-negative constructions have been pivotal in shaping clinical approaches to adolescent health (2006).

In summary, dominant understandings of adolescence and young people’s sexuality play a role in shaping clinical perspectives in sexual health. Sexual and reproductive health issues and clinical agendas are not created in a vacuum but instead arise in the broader context of social normative behaviour and social environments. Therefore, when adults see young people’s sexual activity as a deviant behaviour (Fallon, 2013), or behaviour associated primarily with dangers and deficits, such perspectives can restrict opportunities for providing sexual health care or promoting positive sexual health outcomes. In my study, I have examined ideology as one part of social context that shaped clinical encounters about sexual health. This exploration of the ideas that shape the encounter presented both new difficulties as well as innovative possibilities for constructing more liberating discourses around young people and clinical encounters about sexual health.
Current Practice in Sexual Health: Missed Opportunities

In a careful consideration of the social context of clinical encounters, clinical services that are currently being provided to young people in the area of sexual health must be reviewed. Clinical practice in sexual health with young people is a broad area that involves sexuality education and counselling, pregnancy prevention, and pregnancy-related health services. The section that follows describes how most young people do not receive clinical sexual health care services, even though recommended standards emphasizing the importance of sexual health prevention and counselling have been available for more than a decade (Duberstein Lindberg, Sonfield, & Gemmill, 2008). The quality of research in this area is generally good, and is primarily based on data obtained through surveys of young people and clinicians. Though many clinicians appreciate that sexual health deserves a prominent place in clinical care, there is clearly room for improvement in current primary care practice. A literature review of clinical preventive services for young people in the United States reported in 2009 that clinicians have low levels of involvement in the preventive care of young people, including sexual health care (Solberg et al., 2009). In one Canadian study conducted in Toronto, Ontario, with young people aged 13 to 19 years (N=1216), 83% reported that they had never visited a clinician for any reason related to sexual health care (Flicker et al., 2009). In a study from the United States, which used data from the Medical Expenditure Panel Survey (ages 10-17; N=8464), only 38% of young people had a preventive care visit in the last year (Irwin et al., 2009). In addition, clinical approaches have remained narrowly focused on the risks and problems of the sexual behaviour of young people, often overlooking young people’s motivations (Oliver et al., 2013) as well as the social and cultural context that shape not just young people’s sexual behaviour but the clinical encounter itself.
The primary care visit offers an important occasion to provide sexual health counselling to young people. Current practice guidelines advise that sexual health assessment, counselling, and education should be key components of care (Public Health Agency of Canada, 2008). Young people trust health care professionals and consider primary care providers to be a major source of information on matters pertaining to sexual health (Frappier et al., 2008). In a Canadian survey, 94% of young people indicated that it is the role of health care practitioners to provide them with sexual health counselling (Frappier et al., 2008). Several studies have demonstrated that young people are interested in and willing to discuss sexual health topics, especially when privacy and confidentiality are assured (Tylee et al., 2007). Unfortunately, a significant number (41%) of Canadian young people aged 14 to 17 (N=1171) surveyed about sexual health stated it was difficult to get a health professional to hear their concerns and take the time to discuss them (Frappier et al., 2008). A review of the primary care literature reveals that for many reasons, including low rates of primary care utilization, especially for preventive care, sexual health counselling by nurses and doctors usually falls short of young people’s needs.

Studies in both developing and developed countries show that young people are often unwilling or unable to obtain necessary health services (Tylee et al., 2007). Results from the 2013 British Columbia Adolescent Health Survey indicated that 10% of young women and 6% of young men reported not getting medical care when they needed it in the past year, most often because they believed or hoped that their health problem would resolve without intervention (Smith et al., 2014). In a policy statement from 2008 on achieving quality health services for young people in the United States, the American Academy of Pediatrics’ Committee on Adolescence noted young people have the lowest rate of primary care utilization of any age group in that country. Few young people in the United States attended primary care preventive
visits, and among those who did obtain preventive care, the provision of anticipatory guidance for health behaviours was very low (Committee on Adolescence, 2008; Irwin, 2005). In a national health profile describing access to care for young people in the United States only 66% had a preventive visit (well check-up) in the past year (Mulye et al., 2009). In Canada, where there is universal access to primary health care, Statistics Canada reported that 70% of young people aged 12 to 19 had consulted a primary care provider at least once in a twelve-month period (Carriere, 2005).

When young people do access primary care, however, they often do not receive sexual health counselling from health care providers (Flicker et al., 2009). In a recent study it was found that one third of young people (in three academic and eight community based-practices in the United States) had an annual health visit without any discussion about sexuality (Alexander et al., 2014). In this same study, when sexuality was discussed, the average discussion lasted only 36 seconds. Low rates of involvement in sexual health counselling are especially problematic for young people who welcome the opportunity to discuss sexual health, but tend not to disclose information about their sexual behaviours to clinicians unless prompted (Tylee et al., 2007).

There is no current literature that describes the occurrence of sexuality discussions between young people and physicians in Canada, but a survey from the province of Quebec, completed in 1999 with a stratified random sample of 1,086 general practitioners and 241 obstetrician-gynecologists, found that fewer than half of physician respondents reported routinely inquiring about the number of sexual partners or the use of condoms during general medical visits for young people (Haley, Maheux, Rivard, & Gervais, 1999). According to the survey, physicians did not routinely incorporate sexual history into their practice, and provided minimal counselling about sexually transmitted infections (STI) even in medical visits directly related to sexual
concerns, and there is no reason to think that these practice patterns have undergone significant change. The report from the Committee on Adolescence (2008) also confirmed opportunities to provide counselling or guidance about sexual activity were missed during health visits of young people. Almost half of the visits with young people did not include an opportunity for them to talk privately (without a parent or guardian) with the care provider.

When young people do get an opportunity to discuss sexual health with their care provider, the conversation usually focuses on problems related to sexual behaviours, overlooking opportunities to talk about sexuality and sexual health (Alexander et al., 2014). Most health-related messages about sexuality are narrowly focused on preventing or testing for sexually transmitted infections and pregnancy (Diamond & Huebner, 2012). In their clinical interactions with young people, some studies found, health practitioners typically discussed aspects of risk assessment and danger, rather than the relevance and significance of positive aspects of sexuality, or situational, cultural, and societal factors that may influence young people’s sexual behaviour (Fortenberry, 2009; Oliver et al., 2013; Shoveller, Johnson, Langille, & Mitchell, 2004). In face-to-face encounters, problem-focused clinical strategies involved screening young clients for potentially risky sexual behaviours and delivering messages that promote risk reduction (Canadian Paediatric Society, 2008). In a review of models for risk reduction counselling, Rietmeijer noted that often lists of closed-ended questions serve as a guide to assessment, followed by advice on how to reduce risks (2007).

In summary, findings suggest that primary care providers miss opportunities to counsel and educate young people about healthy sexual behaviours and preventing unintended pregnancies and STIs. Clinical preventive care, including young people’s sexual health care, is in many ways a neglected domain of practice (Shoveller et al., 2010). A better understanding of the
social context that shapes young people’s clinical encounters about sexual health may provide insight into why these opportunities are missed, with a view to informing research and practice.

**Sexual Risk Reduction Interventions**

In this section I review and synthesize empirical findings from selected studies that have evaluated the efficacy of sexual risk reduction with young people in clinic-based settings. In keeping with current social constructions of adolescent sexuality as characterized by deficits and dangers, the intervention studies reviewed here were almost exclusively concerned with preventing negative sexual health outcomes. Therefore, the discussion of sexual health indicators in this review is minimal in scope, limited to the behavioural and epidemiological indicators relating to the avoidance of STIs. This section also includes a brief discussion of the most recent systematic review of clinical interventions that relate to another negative sexual health outcome, unplanned pregnancy. Identifying key interventions that are effective in promoting positive sexual development remains an important but overlooked outcome in the literature (Duberstein Lindberg et al., 2008). Regrettably, positive sexual development remains “poorly conceptualized and defined” (Duberstein Lindberg et al., 2008); the research reviewed is centred on young people’s sexual activities and not young people’s sexualities. More work will be needed to consider the part health care providers play in defining and promoting positive sexual health outcomes, such as positive intimate relationships.

A large number of sexual risk reduction programs for young people have been developed, implemented, and evaluated. However, the development and work towards improving the programmatic efficacy of these interventions has proceeded unevenly and across different venues (DiClemente, Salazar, Crosby, & Rosenthal, 2005). Most programs have been developed and implemented in school and community venues. Although school and community venues offer
important opportunities to deliver risk reduction interventions, a critical but understudied aspect of prevention work are interventions delivered in the clinic setting, especially risk reduction work implemented by health care providers (DiClemente et al., 2005). Furthermore, the studies that are available on interventions delivered in the clinic setting have methodological weaknesses described more completely later on in this section. With limited evidence available to define “what works,” clinician’s delivery of sexual risk-reduction interventions has tended to be driven by the expert opinion of adults, tradition, or the specific structures of different clinical settings.

**STI risk reduction.**

A small subset of empirical findings from sexual risk reduction interventions are those developed and evaluated for use in clinic-based settings. The two most recent systematic reviews of studies that evaluated sexual risk reduction programs for adolescents developed and implemented in clinic settings include studies done after 1990. The first such review, by DiClemente, Milhausen, Sales, Salazar and Crosby (2004), identified only nine interventions (Boekeloo et al., 1999; DeLamater, Wagstaff, & Havens, 2000; DiClemente et al., 2004; Gillmore et al., 1997; Mansfield, Conroy, Emans, & Woods, 1993; Metzler, Biglan, Noell, Ary, & Ochs, 2000; Orr, Langefeld, Katz, & Caine, 1996; Scholes et al., 2003; Shrier et al., 2001; St. Lawrence et al., 1995) that used randomized controlled trial designs. The second systematic review, by Sales, Milhausen and DiClemente (2006), used less restrictive selection criteria, and included the same nine interventions of the first systematic review, plus three additional clinic-based interventions (Clark, Brasseux, Richmond, Getson, & D’Angelo, 1998; Downs et al., 2004; P. Smith, Weinman, & Parrilli, 1997). Both reviews considered the reported efficacy of clinic-based interventions in reducing risk of acquiring an STI. The studies in these reviews were of interventions in a clinical venue delivered both in a group format or by a health care provider
in one-to-one interactions. The intervention content described in these trials varied but often focused on the “proximal” factors relating to STI infection rather than broader determinants of health such as strong connections to family and school. Most interventions provided STI education and condom skills training (Delamater et al., DeLamater, Wagstaff, & Havens, 2000; Gillmore et al., 1997; Orr et al., Langefeld, Katz, & Caine, 1996; St. Lawrence et al., 1995). Other interventions were more broadly based and included additional elements such as risk assessment (Boekeloo et al., 1999), interactive sessions on topics such as gender and ethnic pride (DiClemente et al., 2004), help with decision-making, and education about social and behavioural skills (Metzler et al., 2000), including sexual assertion, refusal, problem-solving, and risk recognition (St. Lawrence et al., 1995).

These 12 studies reported on the efficacy of 12 interventions and isolated key characteristics of effective interventions. They also provided some observations regarding the limited nature of evidence available, including methodological limitations. When considering the efficacy of the interventions included in these two systematic reviews as a group, weak to moderate treatment effects were reported in most of the 12 studies. One third of the 12 interventions reported no significant difference between the intervention and the control group with respect to behavioural outcomes (DiClemente et al., 2004). Considerable variations were noted in estimated treatment effects across studies. An increase in the use of condoms was the most commonly reported treatment effect. Additionally, several interventions described decreased sexual frequency or sexual initiation as a treatment effect. Treatment effects decayed over time, but this problem is considered to be axiomatic to prevention research. Given the modest impacts of the interventions evaluated, it remains unclear if the improvements noted in risk behaviours were of sufficient magnitude to affect the risk of acquiring an STI. Diclemente et
al. suggested that current interventions have not yet attained a level of success that could be considered satisfactory. Future research will be required to compare the relative efficacy of one intervention over another. In summary, the knowledge regarding what sexual health interventions are most effective, over what time periods, for whom, and under what circumstances is not yet well understood.

In addition to measures of efficacy, the clinician looks for answers about what specific characteristics make their programs or interventions successful. Characteristics of successful clinic-based interventions are 1) a focus on a single ethnic group or gender; 2) STI education and skill-building activities (e.g. learning to put on condoms); 3) sexual negotiation and communication training; and 4) personal risk assessment (Sales et al., 2006). In considering characteristics of effective programs targeting sexual risk reduction in a broader sense, and looking to different venues that include but are not restricted to clinic-based settings, a larger number of key elements have been recognized (DiClemente et al., 2004). These key characteristics are 1) the provision of accurate, accessible, and timely sexual risk reduction information; 2) broadly based content that emphasizes the psychological correlates of risk (Sales et al., 2006) and promotes the development and mastery of social skills and abilities (e.g. communication, negotiation, problem solving, social skill building) as well as technical skills (e.g. condom application) through learning and activities; 3) the provision of examples and practice to increase self-efficacy in assertive and effective communication with sexual partners; 4) a focus on motivating young people to use new knowledge and skills for STI prevention; 5) customized prevention messages appropriate to the age, gender, and cultural milieu of program participants (DiClemente et al., 2004; DiClemente, et al., 2005; Sales et al., 2006); 6) a theoretical basis for planned intervention (Sales et al., 2006); 7) multisession interventions
(DiClemente et al., 2004; Metzler et al., 2000; Sale et al., 2006); and 8) a target of behaviours that are reasonable and possible to accomplish (Sales et al., 2006). These intervention characteristics may also be incorporated into effective clinician-delivered counselling in the clinic setting.

The small number of trials (12) considered in these two reviews indicates a paucity of high-quality studies examining effective interventions for young people receiving care in clinical settings (DiClemente et al., 2004). Of these trials, only four included clinician-delivered interventions (Boekeloo et al., 1999; Clark et al., 1998; Mansfield et al., 1993; Metzler et al., 2000). Although all 12 of the studies met some established criteria for rigor (Sales et al., 2006) methodological strengths and weaknesses in this literature are well described (DiClemente et al., 2004). One central methodological issue that has plagued clinic-based STI prevention studies, including the studies reviewed here, has been a failure to specify the intended sample size in advance, with a related problem of a lack of power calculations in the planning stage to determine the required trial size (DiClemente et al., 2004). In addition, control conditions and randomization procedures have been often poorly described. Also, many studies have failed to include an adequate follow-up period to assess intervention effects (DiClemente et al., 2004).

These methodological limitations can yield study results that are imprecise or even invalid. Third, intervention outcomes can be generalized as having, at best, modest impacts on sexual risk behaviours. Though the intent of all interventions is to reduce the incidence of STIs, few of the programs reviewed here met that standard for effectiveness.

The two reviews revealed a very small but reasonably credible body of evidence that demonstrates some positive behavioural impacts of clinic-based interventions on sexual risk behaviour. However, these few studies were still limited in scope; none of the studies reviewed
relate to positive sexual health outcomes such as the development of positive intimate relationships. Working towards positive sexual development is nevertheless an important sexual health outcome (Duberstein Lindberg et al., 2008). My study, in which I analyzed the perspectives of young people and clinicians regarding clinical encounters that aim to promote sexual health, provided an important further foundation for informing practice related to positive sexual health outcomes.

**Unplanned pregnancy as a sexual health outcome.**

The issue of unplanned pregnancy in adolescence is complex and multifactorial in nature (Oringanje et al., 2010). However, since unplanned pregnancy does represent a significant sexual health outcome for some people, it can certainly feature as an important part of the clinical encounter, and still remains to a great degree part of the discourse around risk and danger with sexual activity. For these reasons, unplanned pregnancy deserves a brief mention here, although a complete discussion of unplanned pregnancy prevention is beyond the scope of this study. Oringanje et al. have completed the most recent large and rigorous systematic review to assess the impact of prevention interventions on unplanned pregnancies among young people between 10 and 19 years of age. A thorough search of the literature by Oringanje et al. produced 41 publications on randomised, controlled trials that met inclusion criteria out of the 98 publications that were found. Interventions aimed to prevent unplanned pregnancy in this study were broad in scope, and included community-, religious-, clinic-, or school-based skill building, counselling, or educational strategies. The main finding from the study illustrates that interventions that include multiple approaches, such as combinations of “education, skill-building and contraception promotion” (Oringanje et al., 2010), help to reduce rates of unplanned pregnancy. While this review was useful in reinforcing the need for multifaceted approaches to the complex
problem of unwanted pregnancy, Oringanje et al. did not offer specific guidance to the practitioner. The study brings together many different categories, failing to isolate key components or methods that might be incorporated into effective clinician-delivered counselling in the clinic setting.

**Future directions in clinic-based STI risk reduction.**

Future directions for clinic-based practice noted in the literature include expanding the scope of risk-reduction interventions to go beyond traditional preventive counselling approaches that are individually based. Current thinking in public health practice has shifted towards a more contextual approach that attends to the individual, yet also situates the person in the context of their familial, social, and cultural milieu that serves to shape their sexual experiences and behaviours (DiClemente et al., 2008). In practice, this shift requires the integration of a broader array of risk-reduction activities that include counselling, education, and social support (DiClemente et al., 2004). Clinicians could be trained in different counselling techniques, but alternatively, or additionally, they would act as service “brokers,” referring clients to social service agencies and other clinic services (DiClemente et al., 2004). Counselling, support, and education programs would engage adolescents in opportunities that extend, reinforce, or potentiate the adoption of sexual risk-reduction practices.

Going beyond traditional, individually based, preventive counselling, towards a more ecological approach would represent a departure from traditional practice patterns in clinical care. A move towards a more ecological approach would require a new emphasis on research that involves young people’s input into clinical care design, along with research strategies that address the social context of the clinical encounter. Without addressing the social context in which young men and women navigate their way through sexual health encounters, we cannot
begin to develop effective clinical practices that engage young people. My study represents one important step in listening to Canadian young people and clinicians in urban British Columbia to gain a better appreciation of the complex interactions that shape clinical encounters. The next section highlights the voices of young people in the literature available regarding young men’s and young women’s needs with respect to sexual health care encounters with clinicians.

**Young People’s Perspectives on Sexual Health Education and Clinical Care**

One of the specific research objectives was to bring to light young people’s diverse voices that are not usually heard in the dialogue about sexual health care. Therefore, it is important to highlight research that focuses on young people’s input into the design of services that are planned for them. This final section is a selective review of research about issues raised by young people in Canada, the United States, and the United Kingdom in focus groups and interviews about their perceived needs in sexual health education and clinical care. Though there is general agreement about what kinds of clinical services for sexual health that young people want (Perry & Thurston, 2008), adults have largely framed the content and the process of the one-to-one sexual health interaction in the office setting. Many sexual health interventions and services are planned by adults using an adult health care model and do not approach sexual health care with an emphasis on young people’s involvement (Ensign, 2001; Gahagan et al., 2007; Oliver et al., 2013), so those needs that users perceive are rarely identified. As a result, more research is needed to find out about the unique needs of this age group as well as the complexity of perspectives that emerge at different intersections of sexuality and gender. For example, the health care literature and health care interventions have more frequently addressed the sexual health care of young heterosexual women, but not of young men, so there is relatively little information available regarding the needs of young men in clinical interactions.
Given these gaps in the literature around young people’s self-identified needs regarding the content and process of the sexual health clinical encounter, I have reviewed what is known about young people’s perceived needs in the broader realm of sexual health education and health care. The review is restricted to work centred on young people’s perspectives: interviews, focus groups, or narratives by young people whose goal is to inform health care provision or education. This includes a review of the kinds of health services young people say they want and the content that young people suggest they require in sexual health education, including subjects specifically identified as appropriate for discussions with clinicians. In addition, I have reviewed what is known about young people’s perceived needs regarding one-to-one interactions in sexual health care. The quality of research available in this area is generally good, with most findings based on qualitative work and some quantitative work that I judge to be theoretically and technically sound. In this review I chose not to include editorial and opinion pieces or research from the developing world.

Young people who have been consulted mostly agree about their general requirements for sexual health services (Belifield, 2007; Perry & Thurston, 2008) and primary health care services (Tylee et al., 2007). They wanted services that are culturally appropriate (Soon et al., 2009), respectful (Soon et al., 2009) non-judgmental (Belifield), youth-friendly (Soon et al., 2009), and confidential (DiCenso et al., 2001; Perry & Thurston, 2008). A literature review of young people’s perceived needs in primary care, focused in the United Kingdom, also reported recurrent themes: confidentiality, access to sympathetic clinicians, and friendly office staff (Gleeson, Robinson, & Neal, 2002).

Fifty-four young people in Fort St. James, British Columbia, who provided in-depth interviews on their experiences in accessing contraception suggested that new sexual health
initiatives should be designed to be culturally sensitive and respectful (Soon et al., 2009). These same young people also suggested that existing clinical services be changed to become more youth-friendly (Soon et al., 2009). The focus groups in another study among 83 high school students in Ontario, from both a rural and an urban region, made suggestions about different topics, such as how to improve sexual health services (DiCenso et al., 2001). These young people suggested that assured confidentiality and sensitivity training for office staff would improve sexual health services (DiCenso et al.). In a cross-sectional internet-based study of self-described lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) young people in Canada and the United States, the respondents prioritized providers’ interpersonal skill and how they interacted with clients rather than specific provider competencies (Hoffman, Freeman, & Swann, 2009). In the United States, nearly 100 LGBTQ young people who offered their guidance in a survey and focus group discussions regarding their needs in clinical care settings wanted confidentiality, respect, clinician competency, honesty, and infection control (Ginsburg et al., 2002).

Young people do not want to be told not to have sex, but instead want reliable and timely information regarding their sexuality (Banister & Schreiber, 2001; Frappier et al., 2008) and to be guided in their own decision-making (Aquilino & Bragadottir, 2000). In a Canadian online survey designed by the Canadian Association of Adolescent Health, completed by 1,171 so-called “mainstream” teenagers, most young people (77%) believed that it was the role of clinicians to provide sexual health information so that they could “decide for themselves” (Frappier et al., 2008). In a recent study in the United States, young people (14 to 19 years) who sought care in a publicly funded STI clinic preferred a collaborative approach that recognized their autonomy (Shafii et al., 2014).
Young people and sexual health education.

Current Canadian literature focusing on young people’s expressed needs regarding sexual health education is not extensive. In one study, young people from Ontario in rural and urban high schools said that sexual health education should be more sex positive and place less emphasis on anatomy and the negative outcomes of sexual activity (DiCenso et al., 2001). This study included students’ suggestions on sex education topics. These students explained that current topics did not provide information that they judged to be useful (DiCenso et al.). They recommended that sexual health education should instead highlight emotional and social aspects of sexual health, and include communication and negotiation skills for improving the quality of sexual relationships (DiCenso et al., 2001; DiCenso, Guyatt, Willan, & Griffith, 2002). Young people (aged 15 to 24) in Fort St. James, British Columbia, recruited from a variety of clinical and non-clinical sites, requested less focus on abstinence and “fear-based” content and more on contraceptive options, especially the notion of contraception as a responsibility shared by women and men (Soon et al., 2009). Young people in Nova Scotia reported that sexual health education in their schools lacked relevance and seemed out of touch with their subjective experience (Langille, 2000).

Data collected on sexual health information needs of 4,343 students aged 13 and 14 in high schools in the United Kingdom illustrated a dissonance between young people’s concerns and the current government policies that are directed primarily towards the prevention of unplanned pregnancy and STIs (Forrest, Strange, Oakley, & Team, 2004). Young people did want access to those topics that corresponded with the current direction of United Kingdom government policies—contraceptive options and sexual health services and concrete practices that would help prevent STIs (Forrest et al., 2004). However, young people in this study also
expressed a need for more inclusive guidance about forming relationships, managing infidelities, and identifying and dealing with love, jealousy, and sexual attractions. In addition, they wanted to learn the mechanics of sex and to learn about sexual pleasure, masturbation, and sexual orientations. Concrete information on puberty and physical development was also requested. Similarly, an in-depth case study of 15 young people through focus groups and individual interviews done in a school in northern England also suggested that sex education should address a broader variety of topics (Hirst, 2004): how to ask for dates, dating aggression, gender issues, and a range of sexual activity options beyond intercourse. These studies show that people require conversations in sexuality education in which they are asked what they think and what they want to know (Fine & McClelland, 2006).

Several researchers have noted a missing discourse of sexual pleasure or desire in sexual health education (Allen, 2008; Fine, 1988; Ingham, 2005). Allen, drawing on data from surveys and ten focus groups, suggested that due to a focus on the prevention of sexual risk behaviours, sexual health education in New Zealand rarely acknowledges or provides avenues for discussing sexual pleasure (Allen, 2007a). Little research has been conducted to examine the perspective of young people on this missing discourse of desire in sexual health education, with a few notable exceptions. A recent survey of 1,216 young people in Ontario, using a community-based participatory approach, found that sexual pleasure, healthy relationship, and HIV/AIDS were the “top three sexual health topics young people wanted to learn more about” (Flicker et al., 2009). Allen’s work in New Zealand (2007) included ten focus groups among 81 secondary school students in which participants talked about sexual pleasure. They wanted to know more about it because it was largely absent in their curriculum (Allen, 2007a)—how to make sex pleasurable for both partners—but they anticipated obstacles in teaching and learning about pleasure in the
current culture of schooling. These findings are consistent with Kang, Cannon, Redmond, and Quine’s (2009) study in an Australian population that explored and categorized health concerns identified in 1,000 unsolicited e-mails. The health concerns of the young women in this study related to development, feelings, relationship issues, and sexual practices in which pain and pleasure were significant factors. Like Canadian young people, these young people called for education that addresses emotional aspects of relationships as well as ways to make sexual activity more pleasurable (Allen, 2008; Hirst, 2004). Allen found that young people’s self-identified needs for sexual health information have shown that they claim the right to make their own decisions about sexual issues and to access information that will allow participation in sexual relationships that are both emotionally and physically pleasurable.

**Young people’s perspectives on the face-to-face encounter.**

When 1,171 young people in Canada (aged 14 to 17) were consulted in online interviews about professional consultations for sexual health, the participants identified clinicians as a key resource for information and care (Findlay & Frappier, 2008). However, approximately 41% of these young people reported that it was hard to find a professional who was not “too busy” to address sexual issues. A survey of 358 young clinic clients in the United States in 13 geographically diverse offices and clinics also reported that the clients wished to discuss sensitive topics, including sexual concerns, with a primary care provider, and reported a more positive perception of clinicians and a more active role in client care when such discussions occurred (Brown & Wissow, 2009).

Research findings suggest that young people want to talk about a variety of sexual health issues and address both medical and nonmedical (psychosocial) concerns—to take into consideration the different social contexts in which they conduct their sexual lives (Banister &
Schreiber, 2001; Gahagan et al., 2007; Marcell, Raine, & Eyre, 2003; Schaeuble, Haglund, & Vukovich, 2009). However, more research is required to identify specific counselling models and clinical processes that will be effective for different target groups of young people. Research around clinical consultation with young people has tended to focus on barriers to obtaining reproductive health services, so the diverse perspectives of young people regarding the process and the content of the visit are rarely available. Since sexual health services continue to focus on young heterosexual females, even less is known about the diverse needs of young people, including the needs of young men (Gahagan et al., 2007).

In my research with young people in a Canadian context, I have used a few Canadian studies that address young people perspectives to gain a better understanding of the individual, cultural, and social factors that influence their needs in sexual health care. The study from rural British Columbia that consulted with young people (aged 15 to 24), both male and female, around their experiences in accessing contraception provided specific recommendations from young people around clinical interactions (Soon et al., 2009). These young men and women recommended that clinicians initiate discussion about sexual issues; employ a casual approach to minimize embarrassment; provide extra time to give personal attention and encourage discussion; and seek training to develop the communication skill required to build rapport with clients.

Twenty-eight young women in Nova Scotia were interviewed to seek their advice for improving clinical consultations with physicians (Langille et al., 1999). These young women suggested that consultation could be improved by clinicians initiating sexual health discussions, giving explicit assurances of confidentiality, conveying the importance and legitimacy of sexual
health concerns, and using communication techniques that acknowledged and help diminished discomfort when clients raised sexual health concerns or needed a physical exam.

In the United States, young women, in semi-structured interviews regarding their views about sexual health discussions with physicians, also preferred that clinicians initiate discussions about sexual topics (Ford, Millstein, Eyre & Irwin, 1996). The 27 young women interviewed in this study thought that a broad range of topics beyond contraception and STIs were appropriate for discussion, including sexual activity options other than intercourse, skills for refusing sex, relationship concerns, and decision-making about readiness for sexual activity. Because young people are often too embarrassed to discuss sensitive sexual health topics, they often want clinicians to initiate these discussions (Soon et al., 2009). In another study from the United States of young men and women seeking care in a public health STI clinic (aged 14 to 19) participants described individualized needs in one-on-one interviews necessitating clinic approaches attuned to their level of psychosocial development, sexual experiences, autonomy, and personal preferences (Shafii et al., 2014). Finally, in a study from the United States involving in-depth interviews with 22 Latina and African American girls, Mckee, Karasz, and Weber (2004) explored the context of seeking help for sexual and non-sexual health concerns. These young urban girls sought very personalized care that recognizes sexual health needs as intimately linked with personhood, emotional need, and young women’s developing sense of self.

Since young women are the primary users of sexual health services, and given that existing services do not address young men’s needs well (Belfield, 2007), even less is known about their perceived needs in clinical interactions. Work by Gahagan, Rehman, Barbour & McWilliam (2007) begins to explore some of the needs of young heterosexual males with respect to programming for HIV prevention education in the Canadian context. The study, through in-
depth interviews and focus groups with 50 sexually active young men in rural and urban Nova Scotia, explored these young people’s own experiences and perceptions of sexual health education, with a particular focus on HIV prevention. Central themes in this work illustrated the “disconnect” between sexual health education messages and young men’s perceived needs. Four themes emerged: 1) perceptions of men as knowing a lot about sex; 2) the influence of peer norms; 3) attitudinal and structural barriers to obtaining sexual health information; and 4) concerns around confidentiality. Their findings suggested that normative masculine sexual behaviour can mean young men are not comfortable seeking out sexual health information and that they avoid face-to-face encounter with providers. Though this study does not focus specifically on clinical services, it is important to my study because it begins to address the gendered context in which some young men in Canada experience and find their way through sexual health messages and sexual health services.

Another study in the United States explored how sexual health might fit into the lives of 32 young men in San Francisco high schools (mean age of 15.5 years). This study solicited input on what these young men needed in order to be comfortable visiting a doctor (Marcell et al., 2003). These young men suggested that physicians should be kind, “keep it real” (p. 184), and be attentive listeners who can talk one-on-one. In the two studies from Canada and the United States described above, the themes that emerged from young focus group participants were how male sexuality is constructed, barriers to discussing reproductive health with peers, and structural and attitudinal barriers to fitting sexual health into the lives of adolescent males (Gahagan et al., 2007; Marcell et al., 2003).

In summary, more research remains to be done to address young people’s diverse needs in clinical consultations to promote sexual health. Since sexual health practice is still focused
primarily on meeting the needs of heterosexual females, the complexity of young people’s perspectives on the clinical encounter emerging through intersections of social positioning remains largely unexplored. The two Canadian studies reviewed here were done in a rural area of British Columbia (Soon et al., 2009) and in Nova Scotia (Gahagan et al., 2007) and were limited to the topics of young people’s experiences accessing contraception and young heterosexual males’ perceptions of HIV prevention education and services. Since young people’s specific health care needs are highly dependent on the intersections of gender, age, sexuality and place, my study represents an essential step in exploring the needs of young people in an urban centre in British Columbia.

The sexual health education needs reviewed here suggest that some young people’s perceived needs and sexual health concerns may not be in line with clinical agendas that often focus on avoiding the negative health outcomes associated with penetrative heterosexual intercourse. Young people in these studies expressed a need for education and counselling about social and emotional issues in relationships, including sexual pleasure, conveying some ways in which they may view their sexual health differently than clinicians. The limited amount of research that has focused on young people’s diverse perspectives illustrates the need to include and analyze the voices of young people to achieve a greater understanding of the clinical encounter and the social context that shapes these encounters.

**Gender as a Key Aspect of Sexual Health**

This final section of the literature review clarifies a range of theoretical approaches to gender relevant to my work. The general consensus is that gender is a key aspect of sexuality (Tolman, Striepe, & Harmon, 2003). Research on young people’s sexual health often evaluates gender differences regarding sexual behaviour. Studies about sexual behaviour often treat gender
as a binary variable, male or female, presuming and highlighting the differences in behaviour between young men and young women, with no theoretical justification for this way of approaching gender (Tolman et al., 2003). This method of operationalizing gender mirrors everyday understandings, in which gender is treated as a unitary concept and sex, gender, and sexuality are all joined together as one. While this understanding of gender is dominant, it has been called into question by many contemporary researchers (Knaak, 2004; Tolman et al., 2003). Since gender is a contested category, with a range of possible meanings (Tolman et al., 2003), I take the shared position that such atheoretical assumptions about gender can obscure how gender plays out in research on young people’s sexual health, with the result that the influence of gender in young people’s sexual health remains understudied.

In challenging conceptualizations of gender where it can be operationalized as a single variable, with two possible categories of “male” or “female,” a social constructionist perspective has emerged with important implications for how gender may be addressed in research. This paradigm moves away from the assumption that sex (or the body) is the foundational framework on which gender is constructed. In this newer approach, gender becomes foundational instead, because gender makes us “see bodies and sexual differences in the particular way we do” (Knaak, 2004). This more contemporary theoretical position thus removes the biological basis for understanding claims about bodies and sexual difference.

Within this newer social constructionist paradigm, gender is conceived as an outcome or a process instead of a physical attribute. Viewing gender as an outcome presents possibilities for researchers to examine social phenomena in a different way. For example, instead of analyzing “gender differences with respect to X,” researchers’ attention is shifted towards analyses that
examine how different social arrangements shape the way individuals “do” gender in different social locations and social contexts.

Moving beyond everyday understandings of gender as an individual attribute, social constructionists theorize gender as multidimensional and operating on multiple levels of meaning (Knaak, 2004). Thus, empirical strategies consistent with this conceptualization frame gender as multivariable. To aid in the formulation of these sorts of empirical strategies, Alsop, Fitzsimons and Lennon (2002) described three interrelated aspects of gender that can be relevant in a research context. The first dimension, the subjective, refers to the individual’s subjective sense of being a woman or a man or a girl or a boy, or something else. In the second dimension, socio-structural, gender is expressed as a social institution, and involves the particular ways that women and men are organized within society. Gender is thus constructed by everyday practices and manifested in particular activities and behaviours. The third dimension, the cultural, identifies multiple masculinities and femininities and refers to different culture-based symbolic understandings of what it is to be a woman or a man (or transgendered). By considering these different dimensions, researchers can examine how gender is constructed through social, structural and institutional organization as well as at the level of the individual.

Intersectional approaches, including the approach used in this study, also view gender within a multidimensional framework, theoretically and empirically existing in multiple forms, but such approaches go beyond constructivist understandings, transforming how gender is conceptualized (S. A. Shields, 2008). From an intersectional perspective, people’s lives cannot be represented by singular and distinct social categories. Therefore researchers cannot assume the primacy of any social category, including gender, in the complex task of understanding people’s perspectives and needs. Instead, intersectional approaches have emphasized that gender
should be explored with other social categories (Hankivsky & Cormier, 2009), resulting in the examination of particular intersections of power and privilege, specific social locations that vary according to place and time. It is these intersections and their effects that become the focus of intersectional types of approaches centered on power (Hankivsky & Cormier, 2009). In an intersectional approach, gender, like other social categories and subjectivities, is understood as being shaped by processes of power, and these processes of power operate in concert to construct experiences of penalty and privilege embedded in social identities (Collins 1990, 2000).

A growing body of theory and research asserts that gender is a one key aspect of young people’s sexual health (Gahagan et al., 2007; Tolman et al., 2003). However, current efforts to address, or even account for gender-based norms, have not been well integrated in any formal way into the models of young people’s sexual health that guide practice (Gahagan et al., 2007; Shoveller, Knight, Johnson, Oliffe, & Goldenberg, 2010; Tolman et al., 2003). In analyzing young men’s and young women’s situated perspectives I hope to establish an important foundation for identifying ways that gender as multidimensional, arising within and co-constituting particular intersections of power and privilege, can play a part in shaping clinical experiences.

Risk

In contemporary discussions of young people’s sexuality the concept of risk often emerges as a key idea (Bay-Cheng, 2003; Buchanan & Hughes, 2009; Shoveller & Johnson, 2006). Since those phenomena identified as risks signal their important ontological status in understandings of social context (Lupton, 2013), some discussion of the different ways that risk is given meaning in Western society is relevant here.
Risk is a concept that is understood and applied in a number of ways across different fields of knowledge. Therefore, depending on the discipline, risk has a different ontological and epistemological status, being theorized in different ways, using different methods and frameworks in analysis (Lupton, 2013). This final section of the literature review will discuss the two main ways of theorizing the concept of risk in the social sciences described by sociologist Deborah Lupton.

One main approach to risk perception, and certainly the most common in the health literature, is based on the epistemological position labelled as “naïve realism” represented in technical and scientific disciplines such as engineering, statistics, epidemiology. Based on this epistemological position, risk is understood to be “real,” an objective danger or harm that exists and can be scientifically measured. Using this approach to the notion of risk, calculations are made about specific risks, and predictive models are built that describe how these risks may affect people or populations (Lupton, 2013). Because risks are considered pre-existing in nature, rather than constructed as social facts), the calculations produced tend to be viewed as representing objective reality (Lupton, 2013).

In the field of sexual health the epistemology of naïve realism is represented in both traditional epidemiological research and in cognitive models that seek to predict adverse health outcomes. In traditional epidemiological research statistical methods are used to calculate risks and construct predictive models describing how adverse outcomes might affect specific populations. For example, in an epidemiological study about sexual health, different sexual behaviours might be linked to health threats such as sexually transmitted infection or unintended pregnancy. A foundation in “naïve realism” is also evident in cognitive models of risk perception (Lupton, 2013). Key questions in applying cognitive models relate to how individual subjectively
respond, cognitively or behaviourally, to “real” risks based on objective facts. For example, in
the widely used Health Belief Model (Rosenstock, 1974), developed to explain and predict
health-related behaviours, a subjective assessment is made by the individual regarding the
“actual” risk of developing a particular health problem.

Alternative theoretical positions on risk are described in social constructionist
perspectives (Lupton, 2013). These understandings of risk are based on “weak” (critical realism)
or “strong” constructionist positions. In contrast to the epistemological perspective of “naïve
realism,” these perspectives emphasize “the social,” that is, the social and cultural contexts in
which risk is understood (Lupton). In these understandings risk is not viewed as an objective
phenomena but is instead constructed and negotiated through social and cultural processes. That
is, risk is not recognizable, or knowable, without reference to systems of belief and moral
positions that are connected to sociocultural context (Lupton). Therefore, risk can only be
known, and meanings about risk can only be negotiated through specific locations in specific
social contexts (Lupton). In the area of sexual health, “expert” knowledge, particularly
knowledge emerging from medicine, counselling, and psychology have been central to
constructing and publicizing sexual health risk.

Regardless of the strength of their epistemological positioning (weak or strong
constructivist), social constructionists view risk as having become a more pervasive part of
existence in Western society (Lupton, 2013). Risk becomes a significant political and cultural
concept through which individual, group, and social institutions are regulated, organized, and
monitored (Lupton). Mary Douglas (1985), a cultural anthropologist, notes that certain groups of
people positioned on the margins of society, such as young people, may be singled out as being
“at risk,” and therefore require the application of methods to bring them back towards moral or
social conformity. Social constructionists observe that risk is viewed as something to be managed by human intervention—by “doing something,” implicating elements of choice, blame, and responsibility, as Lupton says, which may be viewed as relevant to clinical practice in sexual health.

**Summary**

This chapter has provided a review of key areas in the literature useful in analyzing how social context shapes clinical encounters about sexual health for young people. Research in critical social theory and sociology has described the dominant view of adolescence as being a time of trouble, noting the strong links established between young people’s sexuality and risk. Yet research findings also show that clinicians often miss opportunities to counsel young people or discuss healthy sexual behaviours or sexuality, even though clinic-based interventions have been shown to have a positive influence on sexual health behaviours. Although there is a significant amount of empirical health literature about barriers and missed opportunities in the provision of sexual health care, less is known about young people’s perspectives regarding the content and the process of the sexual health encounter. Since these perspectives are shaped by intersections including age, gender, and sexuality, it was timely to undertake this research focused on analyzing young people’s and clinicians’ perspectives in Victoria, BC. The studies reviewed here suggest a dissonance between young people’s perceived needs and sexual health concerns, and that clinical agendas often focus on the negative health outcomes associated with heterosexual penetrative intercourse. Finally, this chapter has included a review of various ideas and approaches used to conceptualize gender and risk as key ideas related to sexuality and sexual health.
Chapter 3: Research Design and Methods

This study used qualitative description (Sandelowski, 2000) to understand clinical encounters focused on promoting the sexual health of young people. Qualitative descriptive studies have as their goal careful and nuanced descriptions that may serve as powerful resources for the development of clinical knowledge (Thorne, 2008). These study designs are often eclectic and may vary widely, but usually share some specific design features, described by Sandelowski (2000), that are evident in my approach.

According to Sandelowski (2000), qualitative descriptive studies are committed to a naturalistic orientation, whereby something is studied in as natural a context as possible, without pre-selecting any variable to study and without a firm commitment to any single theoretical view, although they are informed by previous research to some extent. Such studies provide a thematic description of the phenomena of interest. However, qualitative descriptive studies are often informed and textured by other qualitative approaches, such as ethnography or grounded theory methods, and by theoretical perspectives, such as critical theory. The most useful sampling techniques in a qualitative description allow researchers to identify shared and unique patterns across a wide range of demographics, with the ultimate goal of revealing those cases deemed to be information-rich and relevant to the purposes of the study. Data collection techniques typically include focus groups and interviews that can be minimally or moderately structured to obtain the full range of information about events. A thematic analysis for content constitutes a description of “patterns or regularities in the data” (Sandelowski, 2000, p. 338), in which the data are presented in no other terms but their own. The findings in qualitative descriptive studies focus primarily on informational contents, presented in a way that best
reflects the topic under study. Of course, these descriptive summaries often serve as beginning points for further study.

Given my interest in the problem of sexual health inequities experienced by young people presented in chapter 1, I also wanted to analyze how social contexts shaped clinical encounters about sexual health. Therefore, I required a critical approach to data collection and analysis that could “reveal processes of unfairness or injustice within a particular lived domain” (Madison, 2005, p. 5)—the clinical encounter. I drew from select theoretical perspectives within critical theory, intersectionality, and social theory. This “textured” approach, which is inconsistent with “pure” approaches to methodology, is explicitly identified as a feature of qualitative descriptive studies (Sandelowski, 2000, p. 337). Thus, descriptive qualitative studies provide a methodological framework or study design that may contain a broad range of theoretical underpinnings and research method options. As part of this textured approach I will outline my theoretical allegiances, their compatibility, and the ways they informed the study, beginning with critical theory and critical ethnographic methods, followed by intersectional theory, both of which are congruent with select notions about social context described by Poland and colleagues (2006).

**Drawing on Critical Theory and Ethnographic Methods**

My qualitative descriptive research design was informed by critical approaches, especially critical ethnographic methods (Madison, 2005), because these facilitated my recognition of young people and clinicians as fundamental sources of knowledge about their multiple dimensions of social context, and prompted critical reflection on my role as a researcher in studying and representing others. Ethnographic methods of data collection require careful attention to context that can be sharpened with an incisive critical viewpoint in analyses, linking
young people’s and clinicians’ perspectives to wider socio-historical events, with potential for exposing social systems of dominance (Thomas, 1993), and showing how young people’s multiple social locations intersect with differing influences of power.

Before presenting a fuller discussion of theoretical perspectives and the ways that these perspectives have been integrated into this descriptive study, it is important to acknowledge that critical theorists envision the world they inhabit in a myriad of ways, so theoretical pluralism in critical theory abounds. Many fields of study have criticalist schools (Kincheloe & McLaren, 2005); even a brief summary of the most prominent of these schools would be beyond the scope of this study. Given this great diversity, however, it is important to identify how I understand the term “critical”: what makes theory “critical” is a “commitment to justice for one’s own group and for other groups in society” (Collins, 1998, p. xiv). A consensus is emerging among criticalists that relations of power are a basic constituent of people’s existence; such relations define both the productive and the oppressive nature of human traditions (Kincheloe & McLearn, 2005). In light of this consensus, the critical perspective I employed was based on an assumption that certain groups in society have power over others and that certain groups of people are “differently placed within specific political, social and historic contexts characterized by injustice” (Collins, p. xiv). My research agenda aimed to generate insight for practice with potential for creating tangible social changes; the values of critical theorists hold the potential to bring about a more just world, where there is less suffering, and more fulfillment (Kincheloe & McLearn, 2005).

Similar ideas and values have been taken up by other nursing scholars in the criticalist tradition, who have also analyzed power interests between groups within society and how those interests have contributed to creating a variety of health inequities (Anderson, 2004; Browne,
Smye, & Varcoe, 2005; Reimer Kirkham & Browne, 2006; Varcoe, Hankivsky, & Morrow, 2007). These nurse scholars have also contributed toward the development of different strategies across different areas of practice that aim to reduce health inequities (Bungay, 2008).

Research informed by critical approaches involves a particular orientation to methods. It always begins with an ethical responsibility to address unfairness within a particular domain of human experience (Madison, 2005, p. 5). In working towards more fairness or less suffering, the methods employed are intended to dismantle surface appearances and whatever is taken for granted in the processes of conducting everyday life, thus shedding light upon underlying power relations (Madison, 2005). Ethnographic methods reflect a concern for “grounding the phenomena observed in the field” (Basanger & Dodier, 1997, p. 9), so that their location within time and space are carefully described (Baszanger & Dodier, 1997), which is congruent with qualitative descriptive designs. By “resisting domestication,” through critical analysis, to use Thomas’s phrase (1993, p. 7), the researcher makes accessible the perspectives of those whose stories maybe restrained or marginalized, contributing towards emancipatory knowledge. As a result, young people’s and clinicians’ perspectives on clinical encounters about sexual health and the social contexts that shape these encounters were analyzed with careful attention to the power relations.

I drew from Madison’s description of critical ethnographic methods (2005) for guidance in planning and sequencing research activities as well as in considering the ethical issues linked with the research process. Madison identifies several tenets of critical ethnographic methods and these will be reviewed here, demonstrating the points of connection between techniques drawing on critical ethnography and intersectionality as theoretical perspectives. A more specific
description of research procedures and processes and ethical issues will be included in the methods section of the chapter.

Researchers working with critical methods take care to situate themselves in the stories they tell, acknowledging and accounting for their own power and privilege, their biases and the potential effects of their research paradigms (Madison, 2005). Reflexivity is obligatory when subjective researchers contextualize their own positionality: they consider and locate their subjectivity in the work and attend to its effects on their interpretations. Through the research process I worked to understand how my social location as a middle-class Anglo-Canadian researcher influenced my thinking and my experiences within the study. I was challenged to consider how my values, perspectives, and current context as a nurse and a counsellor working with young people all shaped my role in the project and the shifting project of my own identity. Thus exposed, the self and the interpretations of the researcher become vulnerable, transparent, and always open to question (Madison, 2005). In this way, critical and intersectional methods move the researcher away from the relative safety of the neutral or objective observer in the field. This reflexive stance, compelling the researcher to acknowledge their personal power, is appropriate to intersectional analyses with its emphasis on power relations. In fact, Hankivsky and Cormier (2009) suggest that intersectional researchers consider how they might be complicit in “continuing the gaze of ‘othering’” (p. 22) when defining their research questions.

**Intersectionality**

While a firm definition of intersectionality has not been arrived at, broadly speaking, this analytical perspective moves beyond singular categories of analysis to examine simultaneous interactions between diverse aspects of difference. Historically, the concept of intersectionality originated from black feminism in the US, third-world feminism, indigenous feminism, and
postcolonial and queer theory (Hankivsky & Cormier, 2009). The term “intersectionality” was first used by critical race scholar Kimberle Crenshaw (1994), but almost concurrently other scholars were calling attention to the inherent limitations of analysis isolating single categories of difference.

Early work in intersectionality identified that analyses considering categories such as gender or race independently were inadequate because in practice people experienced these social statuses simultaneously (Cole, 2009). Failure to account for the complex ways in which categories of difference rely on each other can result in knowledge that is incomplete or biased. Consequently, the interests and priorities of many vulnerable or marginalized people who experience interlocking forms of oppression (for example, members of racial, ethnic or linguistic minorities) are often poorly served. Going beyond these limitations, intersectional conceptualizations highlight the “mutually constitutive relations” (Shields, 2008, p. 301) among aspects of difference that might include various social categories such as race, gender, sexuality, age, religion, immigration status, class, or ethnicity. Furthermore, intersectional analysis considers these various social categories as well as the influence of processes and systems of domination and oppression (e.g. homophobia, classism, racism, sexism, ableism). A central goal of intersectionality is the inclusion of previously ignored or excluded populations (Hankivsky & Cormier, 2009), providing a theoretical foundation informing appropriate action to advance positive social change. As Collins explains, intersectional analysis is only fully achieved “when abstract thought is joined in concrete action” (Collins, 2000, p. 29)—action that creates coalitions and alliances to lessen social exclusion, poverty, and marginalization (Hankivsky & Cormier, 2009).
Power and intersectionality.

Power is a central concept within intersectionality (Hankivsky et al., 2012). Intersectionally informed approaches are driven by the critique of power—how it operates and its effects (Dhamoon & Hankivsky, 2011). Yet power is a contested concept marked by longstanding debates about the ways it should be understood (Dowding, 1996). Saar (2010) recalls two well-known ways of understanding power in the philosophical tradition: either as domination or as constitution. The first way of understanding power is an individualistic, instrumentalist, and action-oriented conceptualization, where power is understood in terms of the domination or subjugation of wills. The second way emphasizes power as constitution, referring not to the ability of individuals to act, but instead to the way power is a relational entity arising in the “channeling and unleashing” (Saar, p. 11) of various forces embedded in social relations. Intersectional theory implicates both of these ways of understanding power, associating both dominance and subjugation and constitution.

As a critique of power, intersectionally informed analysis may highlight 1) how power, operating at both discursive and structural levels, excludes specific knowledges and experiences (Hankivsky et al., 2012); 2) how processes of power and systems of power shape and construct social identities and categories such as gender (Hankivsky et al., 2012); and 3) how processes of power are relational, operating in concert to shape experiences of both privilege and penalty between and among groups (Collins, 2000).

In conceptualizing power as an “intangible entity” operating within a “matrix of domination” (2000, p. 274), Collins contributes to understandings and analyses of complex webs of social arrangements that are part of intersectional approaches. Collins emphasizes the multiple constellations of social relations created within intersecting systems of oppression. Collins says...
that intersections of gender, class, and sexuality, arranged in particular ways, shape penalty and privilege. Within these shifting intersections are experiences of “power over” others, but also the potential for the power of working together with others—“power with” (Guinier & Torres, 2002). Consequently, the way power is conceptualized is not based solely on domination or oppression, but instead on the shifting processes through which power and inequities are produced or actively resisted. Within this matrix Collins sets out four interrelated domains of power: structural, disciplinary, hegemonic, and interpersonal. Collins’ domains of power include both macro and micro relations that are both socially and historically specific. These four domains are described within a matrix of domination, but could also be used as sites of empowerment.

**Intersectionality in nursing.**

Intersectionality holds much promise and potential, but research methods in nursing that serve to capture its key assumptions remain underdeveloped (Dhamoon & Hankivsky, 2011). Hankisky, Reid, Cormier, Varcoe, Clark, Benoit and Brotman (2010) outlined five reasons why translating theory into methodological practice remains a challenge. First, the theorizing in intersectionality often fails to be connected to the very different work of creating viable research designs. Second, uncertainty remains about when, where, and how intersectional approaches should be applied. Third, the difficulty of applying intersectional principles to empirical designs, especially in disciplines dominated by quantitative research, slows progress. Fourth, there is still uncertainty about whether all possible intersections should be considered at all times, or if some specific intersections might be salient. Fifth, intersectionality seeks to apply health information that does not exist. Often data representing multiple groups and relating significant differences with groups and across social classes and genders are not available.
In spite of these challenges, intersectionality is being recognized as an important theoretical tool or paradigm for research across health disciplines, including nursing (Dhamoon & Hankivsky, 2011). In the words of nurse researchers Van Herk, Smith, and Andrew, intersectionality “critically examines the power structures that govern society and social relations that shape healthcare encounters “ (2010, p. 30) by attending to the political, social, economic, and cultural contexts in which health inequities arise. More specifically, intersectionality has shown potential for nurses in their task of interrogating or enhancing biomedical approaches to health and also in extending research methods such as sex and gender based analysis (Dhamoon & Hankivsky, 2011). Dominant biomedical approaches to health, with their narrow focus on disease, have inadequately represented nurses’ concerns because they fail to consider or nominally consider social forces and contexts that shape health and health inequities (Kelly, 2009).

Van Herk and colleagues also note intersectionality’s clear significance for nursing as a practice discipline (2010). Van Herk and colleagues suggest that examining the entangled social locations of nurses and their clients is an essential aspect of reflective practice because nurses can then take into account the implications of privilege and oppression in the health encounter. Clinicians with good intentions, but without awareness of the power relations at play, may risk imposing “dominant discourses onto marginalized populations, further ostracizing them within the space of care” (Van Herk, Smith, & Andrew, p. 36).

In the realm of Canadian scholarship nursing research is beginning to emerge that demonstrates the importance and the wide variety of intersectional approaches; however, there is still a need for more Canadian work in the field of intersectionality and health (Dhamoon & Hankivsky, 2011). Intersectional theory has been used in by researchers in Canada to examine
health phenomena in nursing in which oppression and power figure prominently. For example, Varcoe and Dick (2008) deconstructed essentialized conceptualizations of Aboriginal populations, identifying a full range of interlocking factors, including gender, poverty, and geography, that influenced health experiences in a rural area. Their intersectional framework included a comparison between the experiences of non-Aboriginal and Aboriginal women to show how similarities existed among all the women, in spite of ethnicity, with regards to how, gender, poverty, and geography influenced the experiences as well as the ways in which racism and colonization affected them in different ways (Varcoe & Dick, 2008). Their study findings revealed how the racist and neo-colonial context of Canadian society creates specific challenges for Aboriginal women which affect their opportunities for health (Varcoe & Dick, 2008).

In another example, Bungay (2013) used intersectionality to examine the health concerns of women who use crack cocaine. Bungay’s analytic strategies included considering interrelationships between intersecting relations of power, systems of oppression, and women’s experiences relating to their health concerns. Bungay’s analysis showed how interpersonal and structural relations of power within the health care system and the welfare and legal systems shaped women’s health experiences.

In a final example, Varcoe, Pauly, and Laliberte (2011) examined how policy processes operate, especially the role of evidence in making policy. They draw attention to different understandings of equity and social justice at play in contexts of creating health policy. Their intersectional analyses highlighted the need to understand complex structural and social factors that shape policy issues and policy-making processes, “highlighting a range of important input points at which evidence might be used” (Varcoe, Pauly, & Laliberte, p. 336).
To realize the full potential of intersectional analysis for nursing research, more methodological development is required so that methods and design reflect innovative disciplinary thinking about equity, identity, and power. With a considerable lag between nursing discourse and theoretical development, much work remains in realizing what an ideal intersectional framework might include (Dhamoon & Hankivsky, 2011) for nursing research and policy. Nonetheless, as I have attempted to illustrate, and as the following chapters will attempt to demonstrate, intersectionality, even at this early stage of development, holds potential for driving nursing research that is more responsive to agendas of social justice.

The relevance of intersectionality.

Clinical encounters about sexual health are generated at intersections of social structure and agency, crafting individual actions and identities, and are made manifest in specific social locations and spaces. Intersectionality, as an analytical tool, helped me explore the processes whereby structure, ideologies, and interpersonal relations shaped the social context of the encounter. Conceptualizing the clinical encounter through an intersectional approach also helped find new ways to theorize the sexual health of young people whose voices are not always well represented in health research.

Like others working within an intersectional approach, I applied the logic that suggests marginalizations at a group level create power differentials, a circumstance that invites research approaches that attend to the interactions of these realities (Bungay, 2008). I have captured some of this complexity by examining multiple interactions of age, sexuality, and gender, emphasizing variations within and across genders. In addition, I drew on select aspects of intersectionality to critically examine how inequities in young people’s sexual health are sustained and created by power relations at work within society. Such an approach was important to my work because
when it is grounded in young people’s situated knowledge it can provide a theoretical foundation for pursuing of social justice (Hankivsky & Cormier, 2009).

**Key assumptions.**

I have drawn from the work of Hankivsky and Cormier (2009) in setting out the key assumptions of intersectional analysis that I have applied here:

1) The central goal in intersectional analysis is to pursue social justice – coalition building and alliances created to join thought with action. The aim is to create shifts in power relations that alleviate suffering.

2) Social lives are embedded in complexity that cannot be delineated into separate factors. For example, simply being categorized as male or female fails to capture the complexity of lived experience. Intersectional analysis does not add categories to each other (e.g. gender with class). Instead, intersecting social categories create distinct social locations and these intersections are a major concern in the analysis.

3) In spite of sharing membership in a specific social group individuals within a group may vary considerably, so there is a need to avoid essentializing members of any group.

4) Intersectionality demands that social categories are understood as fluid, historically situated, and socially constructed, working at micro and macro structural levels.

5) Intersectionality highlights the importance of power relations in creating social structures of domination and oppression.

6) Systems of power are shaped by historical, social and political contexts.

7) Intersectional analysis does not categorize individuals as either privileged or oppressed—a person experiences both oppression and power depending on different contexts that may change over time.
**Intersectionality and social context.**

Poland and colleagues identify six different dimensions of social context, drawn from diverse domains of social science: “power, the body, consumption, identity, pleasure and place” (Poland et al., 2006, p. 62). Derived from social theory for research on tobacco use, these dimensions of social context are valuable in understanding clinical encounters about sexual health, and are compatible with a qualitative design concerned with social context and intersectionality. The frameworks of intersectionality and Poland et al.’s theorization of “the social” (p. 59) all direct the researcher to examine the centrality of power relations that constitute social context. Further evidence of theoretical congruence is demonstrated in Poland and colleagues’ description of social practices, generated at multiple and interactive levels of social structure, that “manifest concretely in specific places” (p. 60). Poland and colleagues also describe a dialectical relationship between social structures and agency (individual action, identity and volition) (p. 60) that corresponds with both intersectionality and my qualitative design aimed at understanding context within the lens of age and gender. Finally, Poland and colleagues also emphasize reflexivity, with respect to both the social location of the researcher (p. 61) and understandings of health promotion as a social practice. This emphasis on a reflexive approach to investigation also complements intersectionality and underlies the researcher’s commitment to name both penalty and privilege wherever perspectives are socially contextualized within an intersectional framework.

**Incorporating intersectionality.**

An intersectionality perspective was integrated in several ways in this study. I recruited a diverse sample to provide insight into the interplay of various social locations, addressing multiple perspectives on the clinical encounter and countering tendencies to essentialize young
people or clinicians as social groups. I designed interview questions to elicit data about how differences influenced young people’s and clinicians’ perspectives. Furthermore, the project of analysis was driven by a “critique of power” (Dhamoon & Hankivsky, 2011), and young people’s and clinicians perspectives were analyzed as being produced in the intersections of different social locations within the clinical encounters.

**Sampling Strategy**

**Choosing study locations.**

To provide “cases deemed to be information-rich for the purposes of the study” (Sandelowski, 2000, p. 338), I chose to include four different types of clinical settings to explore more fully the perspectives of young people and clinicians situated within different structures and contexts. With this purposeful sampling technique, which Sandelowski considers the most useful one for qualitative description, I was able to expand on the shared and unique patterns of found in a range of demographic groups (Sandelowski, 2000). These clinic settings were the Victoria Youth Clinic, the Island Sexual Health Society, University Health Services, and a family practice in a lower income neighborhood. All four clinical sites are located in Victoria, British Columbia.

Intersectionality required that I carefully consider who might be included in the groups of clinicians and young people served at these clinic sites (Cole, 2009). I therefore included different types of clinic sites delivering sexual health services that focused on serving relatively diverse populations, including young people who may be at risk for poor health outcomes. I planned for a sample that would ensure the participation of young people across multiple social locations of interest, considering gender, class, and sexual orientation, all widely recognized in
the literature as variables that are likely to shape sexual health experiences. For example, in Canada, Maticka-Tyndale (2008) observed that different social and economic circumstances interact to produce environments that can threaten sexual health for certain groups of young people, including poor and LGBTQ young people (Maticka-Tyndale, 2008). Additionally, the Canadian Guidelines for Sexual Health education specify that different social situations, including age, gender identity, sexual orientation, and socioeconomic background, be taken into account in the provision of effective sexual health education and services (Public Health Agency of Canada, 2008). Including different practice settings also served to introduce some diversity within the group of male and female clinicians participating in the study, including doctors, nurses and nurse practitioners. Without taking into account diverse social locations, it is not possible to address the complexities emerging in young people’s and clinicians’ perspectives about the clinical encounter.

**Entering the field.**

“Entry” is a common concern for qualitative researchers, and much has been written around entering the terrain of research participants (Madison, 2005). As a researcher I needed to consider ways to enter clinical settings, as well as ways to invite young people and clinicians to participate in the study in a manner that was effective, ethical, and appropriate. While I was planning this project, I worked as a nurse and a counsellor for the Victoria Youth Clinic (VYC), one of the settings for this study. Staff at the VYC reviewed my research summary and offered input. They also requested that VYC clients be invited to participate in the proposed study. In addition, before I entered the VYC field to conduct my research, I reviewed my project with the VYC staff to keep them informed regarding planned research activities and their role in the process. After this review, posters were placed in waiting areas to inform clinic clients about the
study. Clients interested in participating phoned or met with me during clinic times, so that I had an opportunity to explain my role, my purpose, and what their role could be in participating in the study. Clinic patients to whom I have provided care were not eligible to participate in the study, so as to avoid the ethical complexities inherent in the dual roles of clinician and researcher (Banister & Daly, 2006).

Gaining entry to a local family practice setting and to the Island Sexual Health Society, and planning meetings with participants from those settings, required a more formal process to ensure adequate attention to the complexity of ethical and relational issues. To begin this process, I called the executive director of Vancouver Island Sexual Health, whom I knew through my work at the clinic, and assessed the director’s potential interest in participating in the research. When the director confirmed their involvement, I relied on her to advise me on the best method for engaging young people and staff willing to serve as participants. To assist participants in understanding my role, my research, and what their role might be in the process, I prepared a lay summary clarifying basic elements of the research design including: my background and institutional affiliation, the purpose of the research, its end products, participant selection processes, associated risks and benefits, study activities (including data collection and storage methods), and plans that were put in place to protect staff and participants (Madison, 2005).

To access the family practice setting for a research site, medical colleagues helped me identify physicians at clinic settings that served a significant number of young people. I called to introduce myself and outlined my program of study and my research agenda. I arranged a meeting with key participants to review my goals and intentions and to answer questions or concerns about my proposed activities. A need for reciprocity was acknowledged at these
meetings; participants inquired about ways my work might serve (or hinder) individual and community needs. I invited ongoing exchange about reciprocity in my work, making clear my intentions to share “findings” from my research as a work in progress that would not compromise confidentiality. As part of this reciprocity I served as a member of a working group at the University Health Services redesigning clinical services in the area of sexual health. I have conducted workshop sessions for staff focused on preliminary findings from the study, facilitating discussion about the further development of sexual health clinical services in the university community.

Participants.

Fifty young people between the ages of 16 and 19 at the selected study sites participated in this project. Thirty-four young people were participants in focus groups, and 16 provided individual interviews. Older teens were the group of interest in this research because they have more ability to critically reflect on their experiences and their needs. Participants were recruited using pamphlets or posters distributed at clinical or community-based sites. Participants were screened in a telephone conversation or at a brief face-to-face meeting to assess their suitability for the study. Five questions were asked to determine eligibility. Individuals eligible to participate 1) lived in Victoria; 2) were currently housed; 3) spoke English; 4) were between 16 and 19 years of age; and 5) if they were receiving health care or counselling at the VYC, they obtained these service from a clinician other than myself. These eligibility criteria were relatively inclusive and facilitated a strategy of sampling participants that varied with respect to ethnicity, class, sexual orientation, and experiences with sexual health services.

Twenty-two clinicians, nurses, physicians, and two nurse-practitioners participated in this project. Fourteen clinicians participated in two focus groups and eight clinicians provided
individual interviews. Since clinicians deliver most face-to-face interventions on the frontlines of sexual health care, it was essential to hear and analyze their perspectives. This clinical angle of vision was a fundamental part in analyzing the social context of clinical encounters.

Data Collection

As a researcher I relied on data from three sources, drawn from critical ethnographic methods (Madison, 2005): direct observation, interviews, and focus groups. These methods have been substantiated in the empirical literature as well-suited to descriptive qualitative studies (Sandelowski, 2000), as well as critical approaches. Detailed contextualized data are required to describe the basic shape and nature of young people’s and clinicians’ perspectives. Participant observation during clinical encounters was not employed due to concerns regarding participant privacy and confidentiality. However, observation of the physical environment, general patterns of activities, and related contextual information at the clinical sites was valuable because it provided information about the influence of the physical environment (Mullhall, 2003), helping to understand and analyze the clinical encounter as an activity rooted in a concrete milieu.

The primary focus for collecting data was through interview and focus groups, both common techniques used in descriptive qualitative research (Sandelowski, 2000), fulfilling different purposes (Crank & Cook, 2007). Interviews were employed because in-depth dialogue provided an opportunity to bring to light young people’s and clinicians’ voices, exploring meaning and the complexities of their perspectives (Madison, 2005). Additionally, these interviews provided an opportunity to explore more sensitive topics often relevant to sexual health and sexual health practice.

There were several reasons for pursuing data collection in focus groups in addition to the individual interviewing process outlined above. Focus groups expose the social constructions
within which subjects form individual perspectives, emphasizing the kinds of talk people feel more at ease with in a public setting (Thorne, 2008). Thus, the focus group tends to highlight some elements of common experience, while at the same time silencing others. In this way focus groups provide an ideal platform on which to reflect on the ways that social context shapes clinical encounters. In addition, it can be argued that individuals are not as well placed to work through all the experiences, opinions, and perspectives that come up in clinical encounters about sexual health. In the collective exploration of experiences and perspectives of the focus groups, individuals complemented each other by identifying common points of view, pointing out contradictions, and comparing their perceived needs or intentions (Crank & Cook, 2007).

Collective work in groups has been shown to prevent the paralysis of isolation in which different models of experience remain fragmented and divided (Haug, 1983). Haug also noted, that without collective work, society (and clinical practice as one part of the current social arrangements in society) can infinitely (re) produce itself in its present form (Haug, 1983).

Observation.

Consistent with an approach informed by critical ethnography, structured observations at the three clinic sites formed part of my data collection strategies (Hardcastle, Usher, & Holmes, 2006). These observations included the physical layout of the sites, descriptions of people, the nature of interactions observed at the three different research sites, and feelings I experienced in response to the different environments. Since the confidential nature of the clinical encounter and the requirements for informed consent precluded the involvement of participant observers in the practice setting or in waiting areas, my observations were limited to “walk-through” visits when the clinics were not in operation. During these visits I requested a tour through the site facilities by administrative or clerical staff. These observations in the public areas of the clinics were done
with the consent of staff at each research site. In a walk-through visit, I observed a limited number of social practices and some contextual information in a relatively passive way, with limited engagement with clinicians or young people who were involved in the study: an etic perspective (Hardcastle et al., 2006). As part of this walk-through visit, I viewed the clinic and waiting areas and requested information about the different steps involved in a client visit. For example, these steps included initial intake or reception procedures, a waiting period before seeing a clinician, and then a clinical encounter. These guided tours were relatively brief and all were completed in under an hour. However, I had the opportunity to return several times to each site during the data collection process to further develop my understanding of the settings and the participants.

During the observations I wrote down key words or phrases in my notebook to capture what I saw and experience as field notes. However, this writing was purposefully planned to be concise because I also wanted to listen, supporting the development of respectful research relationships. In order to more completely document my observations, after each observation period I took time to make more complete descriptive and analytic notes at a nearby location, in my car, or in a café. During these periods after an observation I also wrote self-reflexive notes about my role in the research process, including my responses to what I observed and the feelings associated with being in the different environments.

It should be noted that my position as an observer at VYC provided a different kind of perspective than that of an “outsider” or uninvolved observer, since I have worked at this site for many years. I had to work harder to gain some measure of clarity about social processes and the influence of spaces that I had come to take for granted. As part of this work I talked about my observations with newer staff members and clients who retained some aspects of an “outsider”
view, helping me to gain more awareness of particular aspects of the environment that had become harder for me to notice.

This type of general observation, made to take into account the significance of place and space on young people’s perspectives, provided an important foundation for interpreting and understanding the context of clinical encounters (Soon et al., 2009). My guide for these observations, inspired by Hardcastle, Usher, and Holmes, is provided in Appendix A.

**Individual interviews.**

In addition to participant observations, I also collected data through interviews with young women and men as well as clinicians. In the interviews with young people, I posed questions about their experiences of sexual health care and their perspectives on clinical encounters for sexual health, as well as the gendered elements in these perspectives. These interviews allowed me to explore sensitive topics relevant to sexual health care, particularly specific preferences around care. Clinician interviews were also an important source of data because the clinicians’ perspectives influence clinical encounters promoting sexual health. In the clinician interviews I posed questions about their experiences and perspectives in providing clinical care around sexual health for young people. All interviews were audio-taped, transcribed, and checked for accuracy. They were semi-structured and based on a set of six questions (found in Appendices B and C) to allow flexibility, while also targeting central points of interest in an ethnographically informed approach. In the interest of attending to the power dynamics in the research role, the interviews ended by allowing participants to take the lead and indicate when they felt the interview was complete.
Young people interviews.

I conducted sixteen individual interviews with young people, including eight young men and eight young women. This was more than I had planned on in my initial proposal, but more voices seemed necessary to develop a sense of what young people had to say.

The interviews with young people all took place at community sites, often at the clinics the participants attended for sexual health care, or in other natural contexts where a private interview space was available, such as community centres or public libraries. Young people were recruited for interviews using pamphlets and posters distributed at clinical or community-based sites. Some young people also volunteered to be interviewed on occasions when I went to pre-arranged appointments to interview other young participants at the VYC. Young men were especially likely to volunteer for interviews in this manner, and young women were more likely to call to make appointments. Informed consent was obtained before beginning each interview.

In the interviews, I began by reminding the participants about the purpose of the study and asking them to talk about what it had been like for them to see a doctor or a nurse for sexual health care. Questions for young people included:

- What do you need when you make a visit for sexual health care?
- What do you want to happen in the visit?
- What makes it work for you? Describe the ideal visit.

Young people as interview participants.

A variety of young people participated in the study, from different socio-economic backgrounds and with different sexual orientations, though the majority were heterosexual and stated that their families had low incomes; all were between the ages of 16 and 19 years. They all lived in Victoria, spoke English, and were housed at the time they participated in the study.
Names of interviewees included in the findings are pseudonyms. Young people were asked to provide information about their age, family income, and background at the time of the interview. The information provided about sexual orientation emerged in the course of the interviews, according to how young people self-identified, in a manner that was respectful to the comfort of participants and consistent with a naturalistic orientation to enquiry (Sandelowski, 2000).

The mean age of the eight women interviewed was 18 years. These young women were either of Anglo-Canadian or East Indian background (see Table 1 for details). Four of them called me to request an appointment time. The other four were interviewed after I met them at the Victoria Youth Clinic in the inner city. Five of the women, including all four who did an interview in the context of their attendance at the clinic, stated that they were part of a low-income family.

### Table 1 Interviewee Demographics—Young Women

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Income</th>
<th>Background</th>
<th>Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katy</td>
<td>18</td>
<td>low</td>
<td>Caucasian</td>
<td>heterosexual</td>
</tr>
<tr>
<td>Sally</td>
<td>19</td>
<td>low</td>
<td>Caucasian</td>
<td>bisexual</td>
</tr>
<tr>
<td>Kindra</td>
<td>19</td>
<td>middle</td>
<td>Caucasian</td>
<td>heterosexual</td>
</tr>
<tr>
<td>Sadie</td>
<td>18</td>
<td>middle</td>
<td>East Indian</td>
<td>heterosexual</td>
</tr>
<tr>
<td>Asha</td>
<td>18</td>
<td>high</td>
<td>East Indian</td>
<td>heterosexual</td>
</tr>
<tr>
<td>Cassie</td>
<td>16</td>
<td>low</td>
<td>Caucasian</td>
<td>bisexual</td>
</tr>
<tr>
<td>Virtue</td>
<td>19</td>
<td>low</td>
<td>Caucasian</td>
<td>bisexual</td>
</tr>
<tr>
<td>Zara</td>
<td>18</td>
<td>low</td>
<td>Caucasian</td>
<td>bisexual</td>
</tr>
</tbody>
</table>

The mean age of the eight men interviewed was 17 years. Participants were of either Anglo-Canadian or Asian-Canadian background (see Table 2 for details). Three of the young men called to arrange an interview; the other five were interviewed in the context of their attendance at the youth health clinic in the inner city.
### Table 2 Interviewee Demographics—Young Men

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Income</th>
<th>Background</th>
<th>Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addicus</td>
<td>19</td>
<td>middle</td>
<td>Caucasian</td>
<td>Bisexual</td>
</tr>
<tr>
<td>Micheal</td>
<td>19</td>
<td>low</td>
<td>Caucasian</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Colin</td>
<td>16</td>
<td>low</td>
<td>Caucasian</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Devi</td>
<td>16</td>
<td>low</td>
<td>Caucasian</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Josh</td>
<td>16</td>
<td>low</td>
<td>Caucasian</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Wray</td>
<td>16</td>
<td>low</td>
<td>Asian</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Jack</td>
<td>18</td>
<td>middle</td>
<td>Caucasian</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Ollie</td>
<td>18</td>
<td>middle</td>
<td>Caucasian</td>
<td>Homosexual</td>
</tr>
</tbody>
</table>

The three participants who called to arrange interviews described their families as middle-class. Two of the young men who were part of middle-class families had never accessed sexual health care and described their perceived needs around future visits.

**Clinician interviews.**

I conducted individual interviews with eight clinicians. These clinicians knew about my project because of their work at the clinic sites, and were aware that I was looking for health care providers to volunteer for individual interviews. I interviewed all the clinician participants at the clinic where they worked, usually in an exam room or an office space where privacy could be assured. These interviews helped to provide a context for the data collected from the interviews with young people receiving sexual health care services. Informed consent was elicited before each interview.

Questions for clinicians included the following:

- What kinds of sexual health care do you provide for young people? Is this something you do a lot of or is this an infrequent event?
- What are the easiest services to provide? What are the more challenging aspects? Why?
• What do you consider to be meaningful elements of sexual health visits with young people?

• What issues and concerns do you think that sexual health providers need to consider at these visits? Describe an ideal visit.

**Clinicians as interview participants.**

The clinicians I interviewed, three men and five women, were mostly middle aged. Two of the youngest appeared to be in their early thirties, three in their forties, and three in their fifties. Demographic data were inferred through observation in the context of the interview, in a manner consistent with ethnographic methods. The three nurses (all women) and five physicians (three women and two men) all worked at the various study sites, so some saw young people for sexual health services in their private practice offices, and others at the Island Sexual Health Clinic or the University of Victoria Health Services. One clinician worked at two study sites, the Island Sexual Health Society and the University of Victoria Health Services. Two of the nurses did not work within the full scope of certified nursing practice in reproductive health, and so they saw young people, mostly women, primarily for education and counselling related to sexual health, mainly birth control methods. I did not interview clinicians at the Victoria Youth Clinic because they are my colleagues.

**Focus groups.**

**Youth focus groups.**

Four focus groups (six to ten participants) were conducted at community sites, meeting at three different locations: a local community centre in a neighborhood outside the downtown area, at the Victoria Youth Clinic’s downtown site, and the adjoining centre for young people, both located in the inner city. There were two groups for men and two groups for women, with a
young adult of the same gender as the participants taking part as an assistant co-facilitator. The co-facilitator assisted with data collection, taking field notes, and helping the lead facilitator in responding to shifts in content and process (Marshall & Shepard, 2006) as conversations evolved. The supervisory committee agreed that the presence of a younger co-facilitator might increase participants’ comfort in discussing ideas about sexual health clinical services, being closer in age to participants.

Some young people were recruited using posters and pamphlets at these clinical sites in Victoria: the Victoria Youth Clinic, the Island Sexual Health Society, University Health Services, and some family practices. Recruiting young men proved to be a challenge, since many men avoid face-to-face encounters with clinicians (Gahagan et al., 2007). Additional male participants were recruited through posters and pamphlets placed in community sites that included coffee shops, recreation centres, tattoo shops, and bus stops. Other young people volunteered for a focus group on the night it was taking place. Participants who called to pre-arrange their participation tended to be more educated and came from wealthier families, and, for example, attended the University of Victoria, unlike participants who joined focus groups in the downtown core on the evening they occurred, who came from lower-income families and were not attending post-secondary education. These differences created focus groups of young people from a range of experiences and with diverse perspectives on clinical encounters for sexual health. Focus group participants were only asked directly about their age, to ensure that they met the age criteria for inclusion in the study. Other demographic data emerged in the context of the focus groups, in a manner consistent with ethnographic methods, inferred through my observation and through the ways that some young people self-identify—for example, with respect to their sexual orientation.
As described previously, potential focus group participants were screened in a telephone interview to assess their suitability for the study using the same criteria described earlier. Focus group discussions were semi-structured and based on a set of six questions (found in Appendix D) to allow flexibility, while also targeting central points of interest in qualitative descriptive research informed by critical theory and intersectionality.

Focus group #1.

The first focus group of eight young women was held at a local community centre outside of the downtown core in Victoria. All the young women who took part had seen a research poster posted at a study site and called asking to participate in the project. All these participants arrived on time, ready to join in the discussion. The group included seven 19-year-old women and one 18-year-old. All of the participants were Caucasian. The emotional atmosphere of this group remained somewhat restrained throughout the session.

Focus group #2.

This focus group included ten young women, five 18-year-olds, four 19-year-olds and one 17-year-old. Half the group had arranged their participation in the group by telephone. The other half joined in because they became aware of the focus groups through their involvement with an inner city youth agency. This created a diverse group of women from different socioeconomic backgrounds. One woman identified herself as Aboriginal. Two women in the group said they were pregnant. Two other women mentioned they attended the University of Victoria. The conversation was comfortable and respectful with all participants contributing to the discussion. During the course of group conversation, a few women indicated they were heterosexual, and one woman stated that she was bisexual.

Focus group #3.
This group included ten young men, eight 18-year-olds and two 17-year-olds. Half of them had telephoned to volunteer their participation, while the other half joined as part of their involvement with an inner city youth agency. Again, this recruitment process created a diverse grouping of young men from different socioeconomic backgrounds. No one mentioned their sexual orientation.

*Focus group #4.*

This group included six young men, two 17-year-olds, one 18-year-old, and three 19-year-olds. One young man who telephoned to volunteer his participation came from a middle-class background, while the other five young men who attended the drop-in centre were of lower-income backgrounds. In group conversation, participants made comments about sexual orientation, but no one discussed their own sexual orientation.

*Clinician focus groups.*

I conducted one focus group for nurses and another for physicians because of their differential placements within the power relations of clinical care. The two focus groups were held at University Health Services during the lunch hour. All the clinicians in the focus groups worked at University Health Services. Recruiting clinicians from the other three study sites proved to be unsuccessful, due to difficulties in scheduling. Colleagues and personal friends were excluded from the recruitment process to avoid the complications inherent in dual roles in the research process. Like the focus groups with young people, group discussions were based on a set of six questions (found in Appendix E), which allowed some flexibility in the structure of the discussion, while also ensuring central points of interest were covered.

*Clinician focus group participants.*
The first clinician focus group comprised six nurses and one nurse practitioner student, all women. In this first focus group, the nurse practitioner student appeared to be in her thirties, three nurses in their forties, one in her fifties, and two in their sixties. The second focus group comprised six clinic doctors and one nurse practitioner—four women and two men (both physicians). In this second focus group, two physicians appeared to be in their forties, one nurse practitioner and one doctor both in their fifties, and two physicians and a nurse in their sixties. These demographic data were inferred through observation during the time of the focus groups conducted in as naturalistic a context as possible (Sandelowski, 2000), in a manner respectful to the comfort of the participants.

Notations and quotations.

The interview and focus group extracts used in this chapter and those that follow are often quoted verbatim, although interviewer interjections and conversational fillers have sometimes been omitted to increase clarity. When conversations are presented interview participants’ names are indicated and the initials “kd” identify me, the principal researcher.

Ethical Considerations

Researchers who aim to bring forward and clarify injustices or obscurities, and then provide just alternatives, must seriously consider the ethical issues in the research process (Madison, 2005). Some of the concerns for my study included informed consent, confidentiality, research relationships, and the need to avoid harm to participants throughout the research process. Approaches informed by critical ethnographic methods have moved beyond utilitarian treatments of ethical concerns towards specificity and context in the research situation. On the ethics of care, the position is not only concern for the treatment of personal relationships with
participants but also for the community and the potential for emancipatory implications in the public sphere.

In this project of working with young people, significant ethical concerns were addressed. The research design and protocols were reviewed by the University of British Columbia’s Behavioural Research Ethics Board to ensure that planned protocols met ethical standards, and a certificate of approval was obtained. In addition to the requirement for institutional review, other ethical concerns were informed by Madison’s discussion of methods and ethics in critical ethnography, and by Marshall and Shepard’s discussion of ethics in focus group research with young people (2006). These ethical concerns included obtaining informed consent, confidentiality, specific ethical issues in focus group research, research relationships, emancipatory implications, and remuneration for research participants.

**Informed consent for individual interviews.**

Informed consent was obtained from each participant prior to interviews. Parental consent was not sought because confidentiality is an essential and well-recognized requirement for providing accessible and quality sexual health care for adolescents (Committee on Adolescence, 2008; DiCenso et al., 2001; Frappier et al., 2008; Ginsburg et al., 2002; Gleeson et al., 2002). Under the provisions of the BC Infants’ Act, young people who seek health care services, including sexual health care services, while understanding the risk and benefits of treatment, are presumed to have the capacity to provide informed consent and to receive care (Province of British Columbia, 1996). In my study, older adolescents (16 to 19 years) who sought out their own opportunities to discuss their experiences and ideas about sexual health care and who demonstrated understanding of the risks and benefits of participating in research were presumed to have the capacity to provide informed consent. To this end, I sought and received a
waiver of parental consent from the ethics review board. Though the issues involved in adolescent decision-making are admittedly complex, there is no specific age set out in legislation or research guidelines that might clearly mark competence to give consent for participation in research (Leadbeater et al., 2006). In addition, previous research has shown that adolescents as young as 14 comprehend their rights with respect to their participation in research (Underwood, Mayeux, Risser, & Harper, 2006).

To increase protection from harm and freedom of choice for the young people who were participants in my study, I provided clear and accessible information that summarized my role as a nurse researcher and the purpose of my research. These participants were assured that choosing to participate or not participate in the research would not affect their health care relationship. Participants had the opportunity to engage in a dialogue about the nature and the intent of the research as well as the nature of their participation, including potentials risks and benefits. In addition, each potential participant was informed about arrangements made to protect their privacy, such as the uses of pseudonyms and security measures put in place to protect all study data. Potential participants had the opportunity to ask questions and have their concerns answered regarding their participation in the study. Potential participants were also given a form to sign, giving the researcher their official written consent prior to any collection of data for the research project. The written consent was kept to one page in length to avoid alienating young participants, particularly disadvantaged or marginalized young people (Marshall & Shepard, 2006).

**Confidentiality and privacy in individual interviews.**

Participants were informed that the interview information would be kept confidential. Participants were also informed about additional arrangements made to protect their privacy, as
mentioned above, with the only exception being in a situation where a young person revealed that they (or a vulnerable sibling) were in serious danger of being harmed (Leadbeater et al., 2006). In British Columbia this duty to report young people in need of protection is outlined in section 14 of the Child, Family and Community Service Act of BC (1996).

**Informed consent, confidentiality, and privacy in focus groups.**

According to Marshall and Shepard (2006), young people in focus groups may not be interested in reading a lengthy set of forms in preparation for focus group participation. To avoid this problem I summarized the contents of informed consent on a flip chart before getting participants to sign their individual forms.

Research participants have rights to privacy and protection, but the focus groups placed some important limitations on these rights that will be reviewed below. In research addressing sensitive material about sexual health, these limitations can take on greater significance. A researcher can make efforts to highlight and request respect for confidentiality in a focus group, but privacy cannot be guaranteed once the group is over. Youth participants not experienced in managing the complex scenario of a group research setting may overdisclose personal information (Marshall & Shepard, 2006).

Preventive strategies to increase privacy and reduce harm included a facilitated group discussion highlighting the concept of confidentiality and its implications for participants. Participants were asked to establish some “ground rules” for the session to protect themselves as participants and to provide them with some measure of power in the research context (Marshall & Shepard, 2006). For example, “ground rules” were established for keeping group discussion content confidential, taking turns, and avoiding judgmental statements. In addition, the risk of personal disclosure was acknowledged along with the use of a “possible scenario” (Marshall &
Shepard) to illustrate some ways such disclosures might cause harm. Well-developed facilitation skills (Marshall & Shepard), along with the provision of sufficient structure in the session, also served to limit overdisclosure—all important strategies to protect participants from harm.

**Enhancing emotional safety for participants.**

Individual interview or focus group participation in research relating to sexual health can be destabilizing, producing subjective experiences that are positive and life enhancing and/or negative or troubling. I used my counselling experience to be responsive to participants who required additional support related to their research involvement. In group sessions, the use of two skilled facilitators for each group helped to assure that sensitive topics did not evolve with so much latitude that emotional safety was compromised. Short debriefing sessions were included at the end of individual interviews and focus groups. In addition, facilitators made themselves available to answer any questions or provide referrals to community resources, including timely access to counselling. However, no referrals to counselling or additional supports were required.

**Research relationships.**

All research projects involving human subjects centre on relationships. An ethical stance in these relationships is more easily achieved when there is clarity around fundamental principles for creating and maintaining ethical research relationships. The following key concepts, inspired by Madison’s work on methods and ethics in critical ethnography, provided guidance in conducting relationships in an ethical manner:

1) Avoid harm or wrong-doing.

2) Remember that my primary responsibility is to the study participants.

3) Respect the well-being of participants.

4) Acknowledge my power, biases, and privilege in study relationships.
5) Be accountable for the consequences of my work.

**Ethics and emancipatory agendas.**

Nurse researchers have a moral obligation, beyond ethical standards put in place to protect research participants, to produce work that has potential to improve care, alleviate suffering, or promote well-being (Thorne, 2008). This moral obligation is consistent with the social justice agenda that is part of critical ethnographic andintersectional analyses, where there is a clear mandate to contribute to emancipatory knowledge. Therefore, one standard by which I have judged this research is its potential to make a positive difference for young people seeking sexual health care.

Critical analyses of relations of power that affect adolescent sexual health encounters can contribute towards some modest shift in thinking around clinical practice, but only if these analyses are shared beyond the confines of the academic community. In the process of gaining knowledge of alternative ways to view the clinical encounters in sexual health, injustices have become apparent, and I have a moral obligation to inform others. To meet this obligation, I will make the results of the study available to young people and clinicians through community presentations.

**Remuneration.**

I elected to provide all participants with a twenty-dollar honorarium for their participation in either focus groups or interview. This honorarium respectfully acknowledged young people’s and clinicians’ expertise and personal contribution of time to the study.

**Analysis**

While this section sets out the specific steps of data analysis, the process of making sense
of qualitative data is complex. Data analysis began with data collection; these two processes occurred simultaneously and in an iterative fashion, using thematic analysis (Sandelowski, 2000). The analysis focused on 1) comparing and contrasting young people’s perspectives and clinicians’ perspectives about the clinical encounter, examining the discrepancy between young people’s wants and needs and the clinical encounters they received and 2) how social context, including power relations, shaped clinical encounters about sexual health, including this discrepancy. In integrating an intersectional approach young people’s and clinicians’ perspectives were analyzed so that connections were built between different social locations and the power relations (Hankivsky et al., 2010) embedded in the encounter.

**Observational data.**

In the early stages of analysis the observation data was set out in text documents. Since one important dimension of social context includes the small episodes of everyday life and their embeddedness in concrete physical environments (Poland et al., 2006), I focused my analysis on how power relations implicated in the creation and maintenance of bureaucracies that serve to discipline and control their staff and clientele (Collins, 2002) were made manifest in the specific research settings. In the analysis I considered as intertwined both the objective (physical setting in the clinic) and the subjective elements (“sense of place”) (Poland, Lehoux, Holmes, & Andrews, 2005, p. 172). When participants commented on the influence of physical settings on the clinical encounter, this complementary source of data was compared and contrasted, and occasionally included as part of the analysis to emphasize particular points. In the later stages of analysis, I revisited this analysis of how place mattered to see how it could provide a more nuanced understanding of the themes extracted from the focus group and interview data.

I discussed my analysis of the observational data with two participants as well as with
another PhD student and former youth worker also familiar with the research sites. This feedback and discussion about the influence of place served to extend and further clarify my analysis.

**Focus groups and interviews.**

The analysis of interview and focus group transcripts followed a two-step approach. Following the inductive development of links and themes in the data that identified patterns and connections as described in the section below, a second stage involved a deductive interpretation of the inductively processed data using intersectionally informed questions that addressed the social locations included in the analysis: age, gender, and sexuality (being sexually active). This staged method of analysis was similar to another example of intersectionality-informed analysis outlined by Sirma Bilge (2009) and also described by Gemma Hunting (2014).

I analyzed data collected from the young participants first, followed by data collected from clinicians. I proceeded in this order because I considered young people’s perspectives that are not usually heard to be foundational to the work. Though the focus groups and interviews were both analyzed using the same processes (Sim, 1998), it was important to ensure that the analysis remained responsive to the fact that the focus groups sought to exploit the social constructions (Thorne, 2008) about the clinical encounter within which subjectivities were formed. Interviews, on the other hand, emphasize meaning and complexities embedded in individual perspectives. In order to remain true to this fact, I analyzed both the interview data and the focus group data separately while reflecting on their nature (Thorne, 2008), wanting to ensure that the findings would “remain true to that reactivity.” However, findings were so similar for both focus groups and interviews that in the final account they were discussed together.

I used a professional transcription service to transcribe interview and focus group tapes into text. Each transcript was checked for accuracy when compared to the recording. Texts from
interviews, and focus groups were read repeatedly to begin to identify patterns (similarities) or unusual events (differences) (Carspecken, 1996) and to develop a sense of the data as a whole beyond the specific elements they contained (Thorne, 2008). Particular attention was given to sections of transcript that highlighted interpersonal power relations at play in the clinical encounter.

In the first step of analysis I read the transcripts thinking about what was said and the meaning of each statement (Crank & Cook, 2007). These meanings were noted in the right-hand margin beside the text. Then going back over the transcripts I “coded” these meanings so that similar meanings were given similar labels. I used coloured markers to highlight codes. Then the transcripts were reread to firm up a list of topics, going back and forth between the transcripts and the topics, and then back to the transcripts.

Once clusters of data began to take shape, I ordered and interpreted the data according to a process for inductive thematic analysis (Sandelowski, 2000) and suitable for research informed by critical ethnographic approaches described by Madison (2005, p. 37):

1) Examine each particular topic within a cluster.

2) Compare and contrast the topic within the cluster.

3) Continue to note and examine the topics within each cluster.

4) Discover overlapping topics; mark differences and topics that could be moved from one cluster to another. Further organization and interpretation reveal topics to eliminate from the study.

5) Compare and contrast across clusters to create links and themes.

In the more developed stages of the analysis interpretations extended beyond simple thematic considerations of similarity and difference. This second deductive stage of analysis
reflected the theoretical sensitivities central to the analysis. In practical terms this required an analysis attuned to intersectional perspectives about relations of power, gender, age, and sexuality and informed by the key insights about social context formulated by Poland and colleagues (2006).

Analysis attuned to intersectional perspectives accounted for the mechanisms through which relations of power operated across different social locations, to shape structures and contexts in clinical encounters for sexual health. The first two questions that follow were considered in this deductive stage; a third was also considered for young people whose sexual behaviour may be viewed as deviant (Fallon, 2013) or associated primarily with dangers and deficits:

1) How does age inform this account? How does age intersect with other social locations in this individual account? (Hunting, 2014)

2) How does gender inform this individual account? How does gender interact with other social locations in this individual account? (Hunting)

3) How does being socially located as a sexually active person inform this individual account? How does being sexually active interact with other social locations in this individual account? This deductive approach required making connections between individual participants accounts, social locations, and the broader context of social relations. This approach required an understanding of the structural aspects of social location as well as aspects that were part of the more personal interactions.

Though the approach of Poland and colleagues (2006) about social context proved compatible with intersectional thinking, it also strengthened my analysis. My analysis treated
clinical encounters as part of the collective social practice, following Poland and colleagues, rather than approaching encounters as based on individual behaviors, attitudes, and knowledge of participants. Through this angle of vision, I could focus on what was most significant and relevant to the social context and the power relations embedded in these contexts.

Furthermore, of the six different dimensions, identified by Poland and colleagues (2006), that could be considered in clinical encounters about sexual health as part of collective social practices, four proved especially useful, providing additional insight in exploring social context. The second dimension of social context, the body, directed attention to the physicality and the social meanings and practices involved in exposing, examining and assessing the body as part of the clinical encounter. Looking for Poland and colleagues’ fourth dimension of social context, with its emphasis on “people’s social representations” (p. 60), helped reveal how a social position can shape the possibilities of what people might think and do in the clinical encounter, ultimately influencing social processes and arrangements. In other words, my analysis illustrated how different groups of people, clinicians, and young people, understood themselves, and how their perceptions helped shape collective practices in encounters about sexual health. For example, the analysis described how, when clinicians position themselves as experts, they shape social behaviours in particular ways.

The fifth dimension of social context identified by Poland et al. suggested an analysis that clearly described the ambivalent position of pleasure and desire in clinical encounters about sexual health. Finally, Poland and colleagues’ sixth dimension of “place” prompted a particular focus on seeing clinical encounters as rooted in specific clinical places and spaces. The physical environment is both a consequence and a condition of clinical interactions, which further
develops the informed sensitivity of intersectionality to the dimensions of “time and space in any analysis” (Hankivsky et al., 2012, p. 5).

The steps of analysis were iterative, based on a pattern of reading and rereading the focus group and interview transcripts, creating links and themes, interpretation and a return to reading and reading, providing opportunity for an immersion in the data (Lincoln & Guba, 1985). An initial conceptual schema emerged after a concentrated period of analysis. This conceptual schema included: clinician as powerful and knowing, young people as ignorant and irresponsible, young people at risk, risk management, silences in a discourse of risk, working in the system, risk and gender, don’t talk down to me, managing vulnerability, positive sexuality matters. This initial conceptual schema evolved as the analysis proceeded and was modified twice.

Further analysis included organizing and grouping coded data to allow for easy retrieval, further comparing and contrasting, and establishing complex links between different sets of ideas. In the final interpretation phase I examined how the themes fit together as well as how they fit the “overall story” conveyed in the data.

I also used the notebook to visually represent my analysis, as well as to record analytic notes to document the stages and development of my analysis as it evolved (Thorne, 2008). In this analytic notebook were lists of themes, which helped me to ask questions about emerging insights or to note patterns that I saw evolving in the data. This record was useful in tracing the development and evolution of my analytic reasoning and to demonstrate the integrity of my final product.

**Reflexivity: Documenting Analytical Thinking and Positionality**

Hall and Callery (2001) describe reflexivity as open reflection about researcher’s beliefs and values in the research process. Reflexivity can help to acknowledge researcher bias,
increasing rigor, while also serving as a means to minimize oppressive power relations in the research process (Vandenberg & Hall, 2011). Reflexivity moves against the notion of the researcher as an objective observer, recognizing instead that research is inseparable from and filtered through a specific view of reality (Madison). In practical terms, by considering reflexivity, I had to focus on the ways that my own subjectivity might influence the data, drawing attention to my social, educational, and personal positions.

As mentioned in Chapter 1, I was informed by my own varied experiences as a registered nurse and as a counsellor. In acknowledging my own history as a clinician, I was aware that I needed to be attentive and reflexive about my position, because there was potential for me to be critical of certain clinical behaviours based on my own perspectives. Thinking about my previous work at one of the research sites made me aware that it would be easier to take for granted some elements in an environment that was very familiar to me.

In this research the ongoing processes of reflexivity helped to account for my position and to address the power imbalances between researcher and participant. Reflexive processes can be engaged through journal writing that documents how the researcher’s perspectives may influence the data (Vandenberg & Hall, 2011). To begin this account I told the story of my own social and historical location in the research process. This necessitated an interrogation of my position as a white, middle-aged, middle-class woman, born in the sixties, talking to young people about sexuality, acknowledging my own privilege, power, and biases. I recorded my preconceptions, my intentions, and the potential effects of the research process. Further journal entries documented how my personal perspectives and feelings operated during the processes of data collection and analysis, shaping the nature and content of the final account. As the work unfolded, I attempted to “catch” my personal agendas, my assumptions about others, and my
ideological positions, writing them down as I saw them coming into play in interviews and interactions with participants (Gubrium & Koro-Ljungberg, 2005) and in the work of data analysis. For example, I wrote about my emotional responses in interviewing clinicians.

I have different emotional response to the interviews. I enjoy hearing about people who take similar approaches to mine, so I have to be more careful to see clearly when I don’t connect, or when I connect a lot to what is being said (Journal entry, p. 51).

By writing in a journal, I was able to focus attention on the power relations embedded in the research process and ways in which these power imbalances were experienced or enacted:

The interpersonal power dynamics have shifted now that I am doing interviews with the clinicians. In interviews with youth I sometimes felt nervous and awkward, but now more so, reflecting clinicians relatively elevated positioning in society, and my own personal tendencies to make myself small in the face of power. Reminders to center myself, to listen well, and remain present. One up, one down, and places in between, though more complicated than that, taking place at so many different levels. No matter, as a researcher I can easily find myself as a fish out of water in so many different ways, but I can’t afford to swim without thinking (without being aware of my power position) (Journal entry, p. 53).

The reflexive process also helped me identify the strong differences that emerged between focus groups conducted with young women and focus groups conducted with young men. Young women’s focus groups engaged easily with the research questions. On the other hand, the young men’s focus groups were more uncomfortable and challenging situations, at least for me as a facilitator. In the young men’s groups, “guy talk” focused on descriptions of sexual encounters or sexual prowess, and teasing humour became a tool to often filter out or
manage any discussion of sexual health. Knight and colleagues (Knight et al., 2012) have also described how men’s conversations about sexual health are centered on their sexual encounters and shaped by masculine hierarchies. Talking about sexual health (for example, STI testing) could be very difficult or even taboo (Knight et al., 2012). In conducting focus groups with young men and raising issues related to sexual health, I was clearly breaking the rules, influencing what might be elicited in the data collection.

In breaking these rules I had the uncomfortable sense of being an outsider, and also of being “exposed,” as a middle-aged woman asking young men to talk about sexual health. There were no conventions or usual conversational strategies to fall back on when my agenda was not a topic of easy discussion. Reflecting on these feelings of discomfort related to my social location helped me to resituate myself within the researcher role, moving the focus away from myself and toward some more effective strategies for listening to participants. In acknowledging the inherent power imbalances between researcher and young participants, I reminded myself that the most important thing that a researcher could do was to listen well (Ensign, 2001).

I also talked about my personal reflections, emotions, and perspectives that I saw at work in shaping the data with my supervisor during our regular monthly meetings. In taking into account my personal responses and my positioning within relations of power I took responsibility for my own subjectivity, identifying choices and power positions and assessing their effects.

Quality Considerations

There are four generally agreed-upon evaluation criteria for a credible qualitative descriptive study (Thorne, 2008), which I used to assure quality in my own project.
Epistemological integrity.

First, a study design with epistemological integrity will include a clear epistemological position set out in theoretical assumptions. In a credible research process, methodology and methods, including research question development, are derived from the stated epistemological position and theoretical assumptions (Thorne, 2008). In this work I have established clear and defensible links between my epistemological standpoint, my theoretical assumptions, and methodology and research methods describe here.

Representative credibility.

Second, a study has representative credibility when the stated theoretical claims are consistent with the sampling strategy (Thorne, 2008). For example, in this study describing young people’s perspectives in clinical encounters for promoting sexual health, set in urban British Columbia, I would not infer that these perspectives reflect those of all young people. Instead, I have sought to attain representative credibility by clearly stating that the research findings reflect no absolute or universal truth, but only one certain type of perspective that I have tried to build “from an auditable set of angles of vision” (Thorne, 2008, p. 89). The different angles of vision that have augmented credibility include multiple data collection strategies and substantive completeness in crafting an approach that brings together different theoretical assumptions relevant to the sexual health of young people.

Analytic logic.

Third, qualitative studies are expected to have an explicit pathway of reasoning that can be followed by other researchers (Thorne, 2008). This means that readers should be convinced by an analytic logic that explicates how the reasoning processes of research occurred, how these
processes are grounded in the data, and the ways in which these processes are linked to interpretations and “findings” (Thorne, 2008). In this study my analytic notes and verbatim accounts of young people’s voices were two methods of constructing and recording an analytic audit trail so that my reasoning processes will be explicit and credible for my intended audience.

**Interpretive authority.**

Fourth, qualitative studies demonstrate interpretive authority when the researcher has taken responsibility and accounted for their own reactivity (Paterson, 1994) within the research process. In other words, readers trust that the researcher’s interpretations reflect some truth beyond their own biases or personal experiences. A credible and trustworthy response in dealing with reactivity in the research process will include a reflexive account where the researcher turns back to look at themselves and their own bias, at their own position of privilege and power. In my notebook, I recorded how my personal perspectives and feelings operated during the processes of data collection and reflected on that data about myself. This journaling represented one important strategy by which I accounted for my own positions of bias and power as I tried to create a credible and trustworthy interpretation of the data.

**Summary**

In this chapter I have described how I have drawn from critical theory, critical ethnographic methods, intersectionality and notions of social context as theoretical perspectives in informing my qualitative descriptive research, to critically describe clinical encounters focused on promoting the sexual health of young people and the social contexts that shape these encounters. My goal in the next three chapters is to describe and critically reflect on the study findings. Chapter 4 contains an analysis of the space and place that examines how place matters
(Poland, Lehoux, Holmes, & Andrews, 2005) in influencing young people’s opportunities for health. Chapter 5 is devoted to an analysis of young people’s perspectives and Chapter 6 contains an analysis of clinicians’ perspectives. The chapters are organized in this way to paint a picture of the clinical encounters, focusing first on the socio-spatial context, then on the actors within the space, bringing to light young people’s and clinician’s voices that are not usually heard.
Chapter 4: The Significance of Space and Place

The social context of the clinical encounter is constructed within the dimensions of time and space. The need to attend to the influence of where people interact is recognized both in critical ethnographic methods and in intersectionality theory. In this chapter I have explored how space and place matter (Poland et al., 2005) in clinical encounters about sexual health. I focus on the interrelationship between power and place in the different settings where the research was conducted. In setting the stage for such an analysis in this chapter, I have described the larger community where the study took place, along with a description of observations at each of the four study sites. Following each descriptive account I have provided an analysis of the significance of place and space in that particular setting and the construction of young people within that context. The chapter comes to a close with an analysis that compares and contrasts across the sites, ending with a summary.

The Research Setting

The research was conducted in Victoria, the capital city of British Columbia. Victoria is located on the southern tip of Vancouver Island on Canada’s Pacific coast in the historic territory of the Coast Salish peoples, which includes the Songhees people. The population of the city is 80,017, but the population of the larger area of Greater Victoria is estimated at 363,100 (Statistics Canada, 2013). Victoria has long been popular as an island tourist destination and continues to attract a significant number of visitors. Major employers are tourism, technology, education, and provincial and federal government administration and services. Immigrant populations account for approximately 20% of people living in Victoria (Greater Victoria Development Agency, 2012). As in other areas of the province, many people identify as
members of a Christian faith, but a large number of people (35% in British Columbia) do not belong to any religion or faith (Province of British Columbia, 2013). Although median incomes are higher than the British Columbia median (Greater Victoria Development Agency, 2012), the gap between income and housing costs is one of the most significant contributors to the persistent problem of homelessness in the capital region (Greater Victoria Coalition to End Homeless, 2013). More than 600 young people in Greater Victoria experience homelessness (Greater Victoria Coalition to End Homeless, 2013). Young people in the region identify poverty among themselves as a significant issue, and young people (15–24 years) participating in a survey on community issues reported that housing, homelessness, and education were top priorities in their community (Victoria Foundation, 2013).

**Power and Place in Community-based Clinics**

Social organizations such as clinics where the research was conducted are included in Collins’ description of the disciplinary domain of power (2002). Collins described how social organizations in the disciplinary domain of power, including health care settings, manage power relations through the creation and maintenance of bureaucracies that discipline and control their staff and clientele (Collins, p. 281). These power relations are managed within specific locales; they “take place” and so become rooted in a specific milieu, being understood differently depending on where people access care (Poland et. al., 2005). Furthermore, clinic spaces and “the emplacement of power relations” (Poland et. al., 2005, p. 171) may be understood differently depending on an individual’s social location (Hankivsky & Cormier, 2009).

Poland noted that most clinicians will have an acute awareness of power relations at play in health organizations as physical settings (Poland, et. al., 2005). Clinicians usually think about, for example, how physical access to the site is controlled, whose clinical agenda takes
precedence, and ways in which those with less power are “treated,” serving to remind them and “keep them in their place” (Poland et al., 2005, p. 173). These are power relations whose key features within bureaucracy are made manifest within specific locales. Within these clinic spaces, physical manifestations of discipline and control will be at play, and these physical manifestations are the focus of the analysis that follows, as in, for example, the spatial arrangements that separate and maintain differences between clinicians and clients (Mullhall, 2003).

**Site Descriptions and Analyses**

**Island Sexual Health Society.**

The Island Sexual Health Society was a non-profit agency that was open to anyone requiring sexual health care. There were approximately 22,000 visits to the agency per year, from a mixed population. Young people constituted the majority of clients served. The services included STI testing and treatment, pap testing, pelvic, genital and testicular exam, birth control and pregnancy testing, and support with decision making around pregnancy, contraception, and sexual health education.

The Island Sexual Health Society’s central location was similar to that of many other sexual health clinics in British Columbia. It was housed in a plain three-storey building just beyond the downtown core, easily accessible by transit. Because the building served many purposes and visitors to the building came and went for many reasons, clinic clients may have a sense of anonymity, and thus privacy. When I visited, I walked down a long corridor that leads to the suite in which Island Sexual Health is located. When I opened the front door of the clinic, I saw four medical office or administrative assistants seated in a reception area partially enclosed
behind glass. The reception area included a file room filled with paper charts. The atmosphere was busy and efficient yet more informal than a regular medical office. The staff members smiled if you make eye contact and were casually dressed. Their interactions were friendly, but business-like. In response to this setting I felt welcome, but I also experienced the mild nervousness that often arises when visiting a health care setting. Even though the clinic was not open when I visited, the office staff was busy: booking clients, managing patient records and referrals, doing the daily administrative tasks required to keep clinic routines running smoothly.

Like many non-profit organizations, the clinic cannot afford enough space to accommodate its burgeoning client population. The executive director who gave me the tour through the clinic mentioned that client volumes have tripled over the last few years, and that clinical issues are now more complex, in part due to the increasing number of young people without family doctors, and the increased number of hours when clinic services are available. She said that the agency outgrew this current space within one year of their arrival there. A hallway lined with seven mismatched chairs served as the main waiting area, supplemented by an overflow waiting area with another set of chairs and a stack of grey plastic storage containers piled into one corner. Any extra available space in this location was filled with desks, supplies, and educational material, providing the familiar picture of a non-profit agency “bursting at the seams.” A billing area has been set up in the hallway along with the waiting room chairs. Beyond the hallway were three medical rooms (two with windows and one without) set up with exam tables in traditional clinic style. There was also a small nurse’s room without a window or an exam table. Farther along the hallway a small room was dedicated to dispensing oral contraceptives; it also included a small display of sex toys for sale. A counselling room staffed by volunteers contained a table, chairs, and a couch. A multipurpose room lived up to its name,
containing three fridges, clinic supplies, a storage area, and educational materials. Small office spaces for regular staff included the director’s office, a nursing office, and a community education office. All these offices were shared spaces, with the exception of the executive director’s office.

Bulletin boards filled with youth-oriented posters covered the walls, which were painted in neutral colours. Younger volunteers provided connection with young people, but there were no younger clinicians on staff. There were no materials available specifically for young men or young people with First Nations ancestry, nor specific indicators that the clinic was a positive space welcoming of LGBTQ people.

The clinic was open during daytime hours, as well as for three evening clinics, plus a Saturday clinic to accommodate clients who work and go to school. The staff included the executive director, an educator, an educator’s assistant, a clinic nurse who worked as the coordinator of clinical services, a billing clerk, a coordinator of volunteer services, volunteer physician assistants, and the nurses and doctors who provided clinical care. The clinic ran primarily on an appointment system, while leaving some room to accommodate drop-in clients. Each clinic session was staffed by physicians whose work brings in funding through fee-for-service billing, but there was not enough agency funding available to provide nursing staff for each clinic shift. This means that nurses were a part of the clinic staff on only two evening shifts and on the regular Saturday shift.

A first-time client going to the clinic began their visit at reception, then proceeded to the waiting area, followed by a visit to the counsellor, then on to see a clinician (most likely a physician). Returning clients may only see a clinician. Drop-in clients and clients requesting
pregnancy testing and pregnancy counselling were designated as “nurse visits” if there is a nurse available on that shift.

In the physical environment, this clinic addressed young people’s comfort by providing both accessible hours of operation and privacy. The clinic also used environmental cues (posters and reading material aimed at an age range of 15 to 24 years) that signaled clinicians’ willingness to address sexual health topics. The look of the waiting areas and exam rooms was gender neutral, but no elements in the environment spoke to young men’s interests. The “decorating” was simple and functional, consistent with the limited financial resources that could be dedicated to the physical setting.

**Analysis.**

The plain building, the crowded nature of the clinic space, and the basic furnishings were manifestations of a physical environment that reflected the relatively low status of the organization within the power relations of health care systems. The sparseness of the built environment reflected the ways that young clients’ need to improve their sexual health as well as the agency’s mandate to respond to that need were devalued compared to other health issues and populations, reinforcing inequities. Because the physical space was inadequate to accommodate the care provided, each room as a micro-space fulfilled multiple purposes beyond that for which it was intended. For example, a waiting area that included a stack of bins also functioned as a storage space. A hallway intended as a waiting area also included a desk so that it could serve as a billing area. With limited physical space, these rooms did not fulfill the purposes for which they were intended, creating an environment that could convey the idea that the care delivered and the care received may be compromised (Crooks & Agarwal, 2008), causing furthering inequities.
Hierarchical structures of power within the agency were made manifest in the use of clinic spaces, with exam rooms provided for doctors, and one smaller room without windows provided for nurses. The executive director, at the top of the hierarchy in the organization, was the only person who did not share her office with other staff.

The spatial arrangements, with the glassed-in area housing the receptionists, who controlled the flow of people and activities in the space, marked off different categories of people and power. The young clients, sitting outside the glassed-in areas, expected to be told where to sit and when to come and go by the older people, the receptionists, inside the glassed-in areas, as part of everyday clinical routines. However, the art and the posters, oriented towards particular young people, served to mark off some spaces in the clinic as their own. In not including art or posters or stickers oriented towards different social locations, including young men, First Nations clients, or LGBTQ people, the environment was not marked as inclusive, creating the potential for limiting the participation of some people in need of care.

Sex toys for purchase, which are concrete evidence of the pleasure that can be part of sexual activity, were situated in a small room away from the main reception and clinic areas, on the margins, representing the uneasy alliance between health promotion and sexual pleasure, with potential for limiting conversation in clinical encounters about pleasure. On the other hand, the presence of sex toys for purchase in a clinic serving young people, regardless of their placement in space, could also be interpreted as working against the dominant discourse that disallows sexual pleasure, thus promoting new possibilities for clinical conversation.

The business-like interactions observed in the waiting area reflected a culture of efficiency. Clinical processes that ran smoothly and quickly helped to maintain high client volumes, resulting in more funding. Crooks and Agarwal (2008) described how busy clinic
environments might be read differently depending on social location. For example, for clinicians and administrators being busy can indicate that the agency is thriving, while clients may interpret this differently, wondering if there is enough time to meet their needs, which could influence what they might share with care providers in clinical encounters.

In this clinic space the young person was constructed as a legitimate sexual person with the capacity to make informed decisions, while still benefiting from guidance and education, which could be viewed as subtle forms of monitoring and surveillance, in making healthy choices.

**Victoria Youth Clinic (James Bay site).**

The Victoria Youth Clinic was a primary care clinic that serves young people aged 12 to 24 who may be at risk for poor health outcomes. The demographics of the clinic population was mixed: white middle-class “straight” young people as well as young people who may be marginalized by various stigmas, such as social status, poverty, ethnicity, lack of education, or sexual orientation.

This clinic provided drop-in, youth-friendly care at two sites, James Bay and downtown, on four days of the week. The Youth Clinic’s James Bay site was located within the James Bay Community Project, a community centre occupying a two-storey office building at the edge of the downtown core. People came and went at the community centre for many reasons; seniors groups, a family centre, family services, and a health co-operative that included a medical clinic also operate out of this site. I have worked at this location for 15 years, so it was difficult to see this place objectively, limiting my interpretations. However, I asked for a tour with the clinic outreach worker to help me observe with “fresh eyes.”
The outreach worker talked about how the clinic operated and how she thinks clients feel about being in the space. The outreach worker thought clients seemed happy to come to the clinic and that they looked reasonably comfortable being in the waiting area, except when the waits get really long (sometimes up to two hours), which was not uncommon. The outreach worker noted that clinic funding was not tied to a fee-for-service model, so the length of visits can be based on client needs, depending on client volume. She said that sometimes there was a lot of talking and visiting between clients, and at other times it was quiet, when people read or just wait without much talking between them. Sometimes the waiting area was so crowded that clients must sit or stand in the hallway or in the building’s reception area.

The outreach worker also showed me the different clinic areas and described what happens in each area of the clinic. We walked through the kitchen and the waiting area adjoining the kitchen, past washrooms along the main hallway, a small stores cupboard, an office area, and two exam rooms. She told me that these two additional exam rooms belong to the health co-operative, but that the Youth Clinic also used them when they became available partway through the shift. Overall the clinic space looked crowded and slightly worn. For example, painted surfaces were scratched and dirty in places and the chairs and table in the waiting area were inexpensive, and also worn and dated. Every bit of space was used for something, with some areas having multiple purposes. The outreach worker mentioned that during part of the day the waiting area for young people was also used as a community soup kitchen, as a meeting place for staff, and for community-living client programs. A freezer was tucked in one corner of the waiting area, and a stack of folding chairs was piled in another corner. The small storeroom was filled to the brim, with scarcely room to walk in and get supplies. The people in the office were crowded in their small one-room office space, which included five work stations and a bookshelf
full of old charts and texts. The physician’s dog sat on a mat under one of the office desks because there was no other space.

The dress code was casual, with some staff members wearing jeans. All the paid staff were women, mostly of middle age, with the exception of the clinic nurse, who was in her late twenties. The staff included an office manager, a nurse, a physician, a counsellor, and the outreach worker. In addition, two young men worked as waiting room volunteers. The staff members talked easily among themselves or on the phone, or worked with client charts. They read clinical notes, viewed lab results, discussed plans for client care, or talked about what was going on in their own lives (family, recent events, personal plans). It was difficult to walk around the office area because of the lack of space: a certain amount of planning was required just to walk through the office space when all staff members are working. This was a busy place with lots of talking and activity. Sometimes clients came to the door of the office to ask staff questions or make care requests.

I felt happy and safe in this environment; because it is so familiar it feels like my professional home. The staff was friendly and welcoming to me, though this interpretation is experienced through my social positioning as an adult, as a researcher and a clinician, among other factors. I also noted feelings of fatigue related to crowded conditions and the volume of work that was done in this small space.

The waiting area, though it served different age groups, was decorated with art by young people. Posters on the wall were aimed at a young audience, but none were specifically aimed towards young men or First Nations people. The stack of books on the table, delivered weekly by an outreach librarian, was for a young audience, and food on the waiting room table was for the young people who often arrive hungry—the baked goods, cheese and crackers, and juice. The shared
health co-operative exam rooms looked grey and bare—institutional—but the exam rooms that belong to the clinic were brightly colored and covered in posters directed to an audience of young people.

At their first visit, clients were invited to fill out a sheet in the waiting area with their contact and demographic information. The outreach worker told me that this form was optional, in the sense that people can still get service if they do not complete the form, or if they prefer not to give their name. However, the option of leaving the sheet incomplete was not explained to each new client, so there was still some expectation of compliance. People who provided limited information at the first visit would later be asked to provide more personal information about themselves after a relationship with a clinician was established. The client may then have to wait for only a few minutes or up to two hours. The client would be called into either an exam room or a counselling area to see a clinician—a doctor, nurse, counsellor, or psychiatrist—depending on their needs or their preferences.

This clinic space attempted to connect with its youthful clientele by providing posters and reading materials appropriate to a 15- to 20-year-old age range; by offering privacy, food, and drink; and by providing environmental cues (posters and reading material) that signalled clinicians’ willingness to address sexual health topics. However, the “decorating” in some of the waiting areas and exam rooms looked worn or “institutional,” demonstrating a less comfortable environment for young people. While the public areas were gender neutral in appearance, no elements in the environment served as cues that would indicate that the services offered here were also for young men.
Analysis.

The crowding of patients in the hallways, the long wait times, the worn furniture, and some exam rooms with very basic furnishings were physical manifestations of the relatively low status of this youth-serving agency within the larger health care and economic systems. The whole clinic area served an adult population in the daytime and when they left, the young people came to be in the space that remained—the leftover space. In this way the clinic space became a physical representation of a population pushed to the margins, furthering inequities. As another example of young people’s needs coming after adults, the waiting area that provided clients with first impression of the agency was never intended for this purpose; it serves as both a community meeting space and a soup kitchen for older people in the daytime hours. The freezer in the corner and the stacks of chairs in the waiting area represented these multiple purposes and took up space that might have otherwise been available for young people to sit down while they waited for appointments. Environments of particular clinic spaces that are not in keeping with the purposes for which they are intended can negatively influence the delivery of care (Crooks & Agarwal, 2008), potentially limiting the quality of the clinician-client interactions in the clinical encounter.

Yet there were also physical objects and processes taking place in the clinical environment that countered this symbolic message of being pushed to the margins, perhaps serving to reclaim (at least in part) some space for young people whose care was deemed important, reducing inequities. The food and drink served in the waiting area, acknowledging both physical needs and the need for psychological comfort, became part of the care delivered and received. Sharing food and the social rituals that surround sharing food created a less formal, less medicalized space in the waiting area. The curated collection of reading material was another physical sign that young people’s needs were being considered. In addition, the waiting
area often operated as a site of socialization and social care brought to being in part through the presence of and in interactions with the youth worker and volunteers.

The presence of two young male volunteers marked out the space as inclusive of young men, signalling that young men’s concerns might be addressed in clinical encounters. However, the most of the art work, posters, and pamphlets symbolically identified the space as one belonging to young women. Though the decor was gender neutral, the exclusion of posters or health information for young men throughout the clinic areas emphasized a more feminized space. While one environmental cue—a poster—signalled a clinic that welcomed LGBTQ people, the lack of art, posters, or stickers oriented towards other social locations, including young men and First Nations people, could limit the participation of some people in need of care.

The walls that enclosed the staff office demarcated different types of people and power relations, reserving space for the older people (staff) who directed and administered the care provided. People who occupied the staff office controlled access to the clinic and set clinical agendas, acting in ways that reminded young people outside of this physical space of their lower place in the hierarchy of the agency. For example, the young people almost always remained in the waiting room until a staff member left the office to call them down the hallway, indicating the start of their visit. While I experienced the clinic environment as friendly and welcoming, young people, depending on their own social locations and interpretations, would experience this space differently, perhaps feeling nervous or possibly frightened when entering a medical setting where they know they would be assessed and/or examined.

Though the clinic was often busy, tightly scheduled and regimented practices and processes were not the hallmark of this environment. The ambience and the dress code were informal for both clients and staff. A dog was part of the regular clinic environment. Clients
often socialized in the waiting area. Visit times varied widely according to client needs and all appointments were drop-in ones, scheduled according to client needs. In this sense the young people and processes in the space were less “regulated” when they visited this clinic than compared to more formal medical settings, reflecting attempts to reduce power inequities.

In this space young people were simultaneously visible, with voices and experiences that mattered, but also pushed to the margins, in terms of their health needs. Here again the young person was constructed as a legitimate sexual being with the capacity to make informed decisions, while still benefiting from guidance and education, which could be viewed as subtle forms of monitoring and surveillance, in making healthy choices.

**Victoria Youth Clinic (downtown site).**

The Victoria Youth Clinic’s downtown site was located in the same building as the Victoria Youth Empowerment Society, an inner city agency. The broad range of services offered here was designed to serve vulnerable youth. Assistance with housing, health care (a clinic), employment, education, substance use and mental health issues, parent/teen mediation, literacy, and life skills are all provided in one location. In addition, the Youth Empowerment Society provides a safe place off the streets with food and access to laundry and shower facilities. This clinic site has an inner city “edge,” with the main entry located in a city courtyard at the back of the building, off an alley. Graffiti and large garbage bins and the smell of urine dominate the alley at the entrance and the short staircase leading to the main door.

Though I have not worked at this site for several years, the location and the staff are very familiar to me. I therefore asked the outreach worker for a tour to help me observe from a new perspective. The outreach worker showed me the different clinic areas and described what happens in each. There is a reception area just inside the entrance where clients are received. An
open glass panel allows conversation between the office manager and the clients entering the clinic. Beyond the panel is an office with four workstations for the two physicians, the office manager, and the clinic nurse. The counsellors work in their own room, just off the waiting area. Shelving for charts and medical supplies are also stored in the office area. There is not a lot of space, but because of the open plan it does not feel quite so crowded as the James Bay site. To the left is a kitchen area opening onto a larger waiting room with couches. Four small exam rooms, the counselling room and a washroom area are also located off the central waiting area. Some walls are brightly coloured and a large work of abstract art hangs over the biggest couch in the waiting area. Other wall surfaces are old brick or chalkboard surfaced so that clients or staff can draw on them. A bookshelf with reading material for young people and a coffee table furnish the waiting area. Posters in the waiting area are focused on youth health issues, including sexual health. There are poster directed towards LGBTQ and First Nations people, but none specifically aimed towards young men. The overall impression is that the space has been created to appeal to young people and to provide comfort—food, drink, and something to read or look at while they wait.

The outreach worker observed that this clinic space and waiting area could be busy and crowded during peak periods. She thought that most clients seemed comfortable to come to the downtown clinic but she noted that sometimes the atmosphere was “intense.” Street issues or mental health issues, when angry or agitated clients were in distress, could require her active intervention. Clients who drop in for services have variable wait times before their visit, ranging from just a couple of minutes to as long as two hours, depending on client volumes. Clinic funding is not tied to a fee-for-service model, so visit times may be longer depending on client needs. The client is called into either an exam room or a counselling area to see a physician,
nurse, counsellor, or psychiatrist, again, depending on their needs or their preferences. At their first visit, clients are invited to fill out a sheet in the waiting area with some of their contact and demographic information. As at the James Bay site, the form here is optional, in the sense that people can still get service if they do not complete the form, or if they prefer not to give their name.

The dress code here was also casual. Since the same staff work at both sites, they will not be described here again. Before the shift starts, staff members chat between themselves about current events (family, personal plans, clinic business). They also discuss client care, review lab results, or make phone calls. I feel happy and safe in this environment, too, because it is familiar. The staff members are open and approachable when I talk with them, and the emotional atmosphere is calm, but focused.

This environment was age-friendly, with posters, art, and reading material targeted towards young people, as well as food and drink and bright surroundings. Also, there were several clear environmental cues (posters and reading material) that signalled clinicians’ willingness to address sexual health topics. However, the clinic’s location at the “edge” of the inner city could decrease the comfort level of the environment for some young people. The “decorating” of the public areas was gender neutral, but again no specific environmental cues indicated that the sexual health services provided were also targeted towards young men.

*Analysis.*

The downtown site was created to serve vulnerable young people. It could be argued that an inner city location is more accessible than a site such as the James Bay one, because it provides care “closer to home,” and medical and social care are easily obtained in one place, thus reducing inequities. However, power relations remain a key feature when health care for
marginalized young people is relegated to the back alleys of the urban core, surrounded by garbage, dumpsters and the smell of urine. Such a setting supports the classist and ageist forms of discrimination that remind vulnerable young people of their (lower) positioning in society. Since this was a place created for “them,” in some ways it promotes the exclusion of young people who may be socially marginalized from other healthcare settings.

The harsher aspects of the environment outside of the clinic site were offset by attempts made inside the walls to (re)claim this space in some measure for young people. Once beyond the reception area, the ambience of the clinic served as an interruption to the harder life beyond the walls. The interior, providing warmth, food, sleek couches, a kitchen table, books, magazines, posters and artwork, was designed to create a comfortable environment and thus distance from the street. Nevertheless, the street “intruded,” a target for intervention if angry drug-induced behaviours interrupted the usually calm atmosphere.

The sliding glass panel at the clinic entry also served as another reminder of the politics of place. The sliding glass panel in the reception area was a physical boundary that denoted authority and separation between different groups of people, between staff and clients. Clients who stood in front of the opening in the glass panel to request care and explain the nature of their needs were easily seen and overheard by the clinicians in the room, a setting that compromised client privacy while privileging security. As Poland and colleagues have noted (2005), there can be a visible tension in health care settings between care and security requirements, embedded in a broader agenda of the social regulation of deviance, where surveillance is the primary method of control.

Against this subtle agenda of social control, the clinic has attempted to loosen the control imposed on clients accessing the clinic. Intake procedures are more flexible compared to
traditional medical practices and the funding model allowed clinical encounters that were based more on client needs instead of time efficiencies, compared to fee-for-service practice. Social interactions visible in the clinic space were casual, matched by the casual appearance of the staff, working to diminish power inequities between staff and clients. When the outreach worker “intervened” with angry or distressed clients to meet their needs, they were not excluded from the space or from accessing service, as might be the case in other clinical spaces outside of the downtown core.

In the final evaluation, there are multiple truths and a diversity of perspectives required to understand the influence of space operating in this downtown clinic, heavily influenced by social location. The young person was constructed as pushed to the margins while at the same time as mattering very much. Their health needs were considered in a space that was made for them, but these needs were met in one the poorest areas in the urban core. Within this space they are viewed both as legitimate sexual persons with voices that should be heard as well as potentially demonstrating risky and dangerous behaviour or in need of control; care, security, and social monitoring of young people all happened within the same locale.

**University of Victoria Health Services.**

Health Services was a primary care clinic for students at the University of Victoria. It also provided orthopedic services, sports medicine, psychiatry, functional medicine, and health education services. The clinic was open Monday through Friday during business hours. At the time of my tour, just before the clinic opened for the day, there were five physicians, five nurses, one psychiatrist, and five administrative support staff on site.

The Health Services building was situated on the edge of the university campus. It was an unassuming one-storey building built during World War Two that blended in with the residence
buildings surrounding it. The clinic space had an old-fashioned feel to it, with its white walls and linoleum floors, an interior space designed in the late 1960s inside an old house. Currently the clinic accommodates 35,000 client visits each year.

When I walked in the door, I felt a busy atmosphere, but also a sense of calmness. Receptionists smiled if you made eye contact, and the dress code in the reception area was “office casual.” Their interactions with me were pleasant but business-like. Nurses wore scrubs, and physicians wore casual clothing, though usually not jeans. When I was introduced to a nurse and a doctor, their responses were friendly and warm, perhaps influenced by my social location as a clinician and as a researcher. The reception area was located just past the front entrance, behind a counter where clients checked in for either a walk-in visit or a scheduled appointment. A member of the clerical staff asked the client to describe the reason for the visit and then directed the client to a waiting room directly across from the reception area. In the waiting room, a set of fifteen office chairs lined three walls of the room. A few posters on the walls were related to aspects of health such as nutrition and physical activity, but there were no posters specifically about sexual health. Instead, pamphlets or posters about sexual health were located inside washroom stalls or in exam rooms.

The rest of the centre opened up along a hallway in either direction from the central waiting room. These clinic areas included a meeting room, a kitchen area, a nursing station, an office area for physicians, a treatment room, washrooms, the director’s office, and ten exam rooms. A separate small waiting area at the end of the building was for psychiatry appointments.

Each exam area was equipped with a desk, a computer for charting, a standard exam table, a sink and supply cupboard, and several bulletin boards filled with health information posters and pamphlets, including some that addressed sexual health topics.
When a doctor or nurse was ready to see a client, the nurse seated the patient in an exam room. Physician visits for sexual health vastly outnumbered nurse visits and this is partly because nurses only provided birth control information and advice related to birth control methods.

During my visit, administrative staff were answering phone calls or booking appointments. Nurses were doing paper work and physicians were either seeing patients or doing charting in their office area.

In response to this environment I felt welcome, but again experienced the mild nervousness that often arises when visiting a health care setting. The empty waiting room, with few pictures on the walls and sparse furnishings, did not promote any emotional engagement with the setting.

This environment connected with young people in terms of its accessible hours of operation and in offering a choice of service provider. However, the spare furnishings and the empty spaces on the wall created an “institutional” feeling that did not increase the comfort level in the setting. Some pamphlets and posters covered sexual health topics, but because of their location they did not easily serve as environmental cues that signalled the organization’s inclusiveness or their willingness to address sexual health topics. Public areas were gender neutral, with no reading material or posters to indicate that sexual health services were available for young men, LGBTQ, or First Nations people.

**Analysis.**

This clinic site, situated in an old building on the edge of campus, represented its low position in the material order of a relatively wealthy institution. The waiting area was notable primarily for its sparse decor and functional use of space—clean and tidy, except for a few
posters, the walls were bare. This was a place for clients to sit and wait, no more and no less. When their turn came, they entered a clinic site that was conservative and conventional in style, even old-fashioned. A traditional approach to care was suggested by the white walls, the nurses in uniform escorting clients down the hallway, and the older style of clinic layout that featured many small rooms. The nurses did an assessment in preparation for the doctor’s history taking and examination. These nursing assessments and interactions were referred to in a clinicians’ focus group as “warming up the patient.” Nurses, doctors, clients, and client visits were relatively regulated within the space, prioritizing timely access, clinical hierarchies, and being efficient.

Hierarchical relations of power were also represented in the physical space by separate areas created for physicians’ work and nurses’ work: a physicians’ room and a separate nursing station. This separation of practice space was a physical manifestation of both the nurses’ more limited scope of practice in this environment as well as the separation of nurses’ and physicians’ roles. Nurses wore uniforms and physicians did not, additional concrete representations of power inequities. Like the other clinic sites, there were spaces that clients did not enter—the physicians’ room, the kitchen, the administrative area, and the director’s office—additional examples of physical boundaries that sorted people into different categories.

This clinic primarily served young people, yet the space was not marked in any visible way as belonging to either young people as group or specific young people from diverse social locations. Therefore, young people were in some ways rendered less visible, constructed instead within the category of adult. The environment signaled that sexuality was a topic that could be discussed within an (adult) medical framework. Consequently, young people were constructed as
legitimate sexual beings, but ones who should confine their discussions about sexuality behind closed doors, where privacy and confidentiality were assured.

**Family practice site.**

The family practice office that I visited as part of this study was, like the James Bay site, situated on the edge of the downtown core, part of a set of storefront-style offices. It provided primary care for a diverse population of patients of all ages, with a focus on adult care. While young clients of the age range included in my study did come to this family practice, they represented a small fraction of the patients in the practice. I sat in the waiting area and observed the activities going on around me until the doctor was ready for our interview. I observed the business of running a medical practice: charts were being updated, referrals were being made, phones were answered, billing codes were recorded, all to ensure the smooth functioning of patient visits. This therapeutic setting was organized for efficiency, functionality, and the business of care.

This was a group practice, including both family doctors and a specialist. The first room for the visitor was a fairly large waiting area that can seat at least fifteen people. There are no health-related resources for clients in the waiting area. Instead the emphasis of its decor was to create a space that was clean, organized, and business-like: walls painted in neutral tones, hung with framed art; a magazine rack; a small section of toys for younger children. There were four medical office assistants (MOAs), one for each doctor, each with their own separate compartment behind a counter, each compartment equipped with a sliding glass panel that can be pushed to the side to allow conversation between the MOA and the patient. Behind the MOAs, but visible through the glass panels over the counter, was another room full of patient charts on
shelves. This area was about the same size as the waiting area. As I moved towards the back of
the office space, I saw patient exam rooms, a washroom, and an office area for physicians.

The MOA who greeted me helped me find the right window for the doctor’s MOA. She
smiled and her voice was friendly. However, the doctor’s MOA did not smile or make eye
contact. She was a middle-aged woman, conservatively dressed in knit slacks, a blouse, and a
jacket. After I introduced myself, she told me about various office procedures which she had
been told I would want to know, without asking specifically what I was interested in. Then she
stopped and said, “That is probably more detail than you wanted.” Her non-verbal signals
suggested that my presence and my questions were irritations that she would have to put up with.
Nonetheless, she was willing to tell me about the office procedures that she considered relevant
in terms of processing clients through an office visit. She informed me that when clients leave
the reception area she sometimes weighed and measured them, or asked them to pay fees or fill
out forms. During this conversation she was seated behind the counter with me standing and
listening on the other side.

The MOA told me that a client should call the office to make an appointment for a sexual
health visit; each caller was asked to describe the reason for their visit. This inquiry was meant to
help decide on the time that should be allotted to the visit on the schedule and to “give the heads-
up” to the doctor. The MOA laughed, noting that when young people want to make a sexual
health visit they usually say “it is personal.” The MOA added that she does not press for details.
At the first visit the client fills out a medical review/background form. At future visits the client
is requested to complete a medical review of symptoms form. Clients sit in the waiting area until
the MOA calls them in to see the doctor. Then they wait in an exam room until the doctor is
ready to see them. The wait times are variable but usually brief, not exceeding 15 minutes.
For the second half of my visit, the visit with the doctor, I was called in to sit in a small exam room with the doctor I was going to interview. The doctor was dressed in slacks, a belt, and a striped shirt with a collar. The contents of the taupe-coloured exam room demonstrated an emphasis on function—an exam bed, a chair for the patient and one for the doctor, medical office supplies neatly arranged, and a clock ticking on the wall.

In this environment I felt nervous. I worried that I might be taking up the doctor’s time. The entire office felt like a place where it is best to follow the rules and fit in with prescribed expectations; the phrase “I had better behave” came to mind.

This physical setting—from waiting room to exam room—lacked any connection to young people, with no posters or reading material aimed towards a young audience. There were no posters or other environmental cues that could reference the inclusion of young men, First Nations, or LGBTQ people in the care setting. The clinic operated only during school hours, and because of the nature of family practice, there was only one choice in service provider. None of the materials in the waiting areas provided cues that would indicate the clinician’s willingness to address sexual health topics. The family practice waiting area was gender neutral. The physical setting was oriented more towards the business of providing health care and less towards creating a sense of comfort for clients, though these orientations are not necessarily incompatible.

Analysis.

This clinic site lacked connection to young people and their needs. The items placed in the waiting room were for adults or children: the magazines for adults, the toys for children, but no items placed in the waiting area that would signal how the interests or comforts of young people had been taken into account in designing the space. The hours of operation were during school hours. Clinicians and office staff were middle aged, so there were no younger service
providers on site. Furthermore, a successful visit to this site required a certain level of health literacy—knowing “the rules” that operated within the clinic setting. This set of rules required that visitors show up on time, quietly wait their turn, fill out forms correctly, and look at least somewhat confident in having mastered the unspoken protocols of the environment. These “adult” rules held potential to exclude more marginalized groups in society, such as young people, limiting access to care. The lack of posters or pamphlets “advertising” sexual health or an inclusive environment may have negatively influenced the clinical encounters, limiting what may be discussed.

The spatial arrangements in the office, especially the waiting room with four MOAs, each seated behind their own glass compartments, differentiated clients from staff, since the panels were opened only when there was a need to connect with the client on the other side of the glass. If there was going to be contact with the MOA it was going to be from a distance, and perhaps on their terms, conveying a less personalized approach to care. Such a perception can negatively influence the way patients understood the care provided and in turn shape client-clinician relationships. The sliding panels were physical elements signaling power relations at play, which also served to regulate activities within the space, where the one clear goal was to process a smooth flow of clients through an efficient system. In contemplating these efficiencies, it would be easy to see how this system could “fit” within a broader systems of power.

At this clinical site, business, security, and care imperatives were all held in tension within one space, which could negatively affect clinical encounters about sexual health. Medical environments where processes, spatial arrangements, and decor emphasized efficiencies over care can be interpreted by young people as places where they will not discuss their sexual health concerns: “it’s not really the environment—, it’s not, like, friendly and inviting. It’s like, you
Another participant explained: “Even the colour on the walls. Even that makes a difference. No one would want to go into some sterile room and be like, okay can we talk about this now?” Since this environment does not take into account young people or their concerns, they are constructed here as invisible, subsumed within the categories of children or adults.

Comparing and Contrasting Across Sites

Though the emphasis in this analysis was placed on the specific contexts in which care was provided, further analyses were relevant in thinking about the “emplacement of power relations” (Poland et al., 2005, p. 171) in sexual health care settings between and across sites. Each site was located in a relatively poor part of town and/or care took place in physical settings that were built and furnished with limited budgets. These spaces and places conveyed the message that not only young clients but also the mandates of clinicians to improve sexual health were devalued and marginalized compared to other health issues and populations, which reinforces inequities. It can be argued that this process of marginalization was made manifest but was also a consequence of the spaces and places where care was delivered.

Each site also featured physical boundaries that sorted people into categories, often representing tensions between security and care (Poland et al., 2005). Such a tension reveals the compromises that are often taken for granted as a necessary feature of community health settings, which nonetheless indicate the inequities embedded in these contexts as well as the ways that young people as a group are constructed. In addition, every site had areas that were reserved just for staff, separate from clients. This use of space, where one group is not allowed, can serve as a reminder of regulatory agendas that keep young people “in their place.” Hierarchical structures of power separating different categories of clinical staff were also made
manifest by the architecture. The family practice setting had areas designated for MOAs and separate areas where physicians worked. The Island Sexual Health Society and University Health Services also had separate rooms designated for nurses and physicians, making visible the power relations as well as the culture of these settings, further highlighting different inequities.

Young people were constructed differently in different health care settings, interpretations of their social locations being changeable depending on place and space. Most often, young people as a group were seen as legitimate sexual beings, though also as people in need of guidance. However, in some clinical settings they were constructed in other ways. For example, at the downtown youth clinic they were also constructed as perhaps risky and dangerous, or in need of control. At the University of Victoria Health Services and at the family practice site, young people as a group could be rendered invisible because they were assumed to belong in the categories of children or adults.

**Summary**

The contribution of this analysis is to articulate how place, as an important dimension of social context, may influence practice (Poland et al., 2005) and the construction of young people at the different research sites. A place-sensitive approach to practice can help clinicians “see” place and space as changeable, directly shaping practice and young people’s experiences of care. The spatial dimensions where care takes place are power relations made manifest, perceived and experienced through interpretations that depend on our social location (Poland et al., 2005). These clearer perceptions may “inform practice and open it up to critical scrutiny” (Poland et al., 2005, p. 178) and thus invite clinicians to realize how place matters, making it one important lens through which to view practice.
Chapter 5: Clinicians’ Perspectives

In this chapter I analyze and critically reflect on the perspectives of clinicians on clinical encounters aimed at promoting sexual health. As I outlined in Chapter 3, in addition to observing the different clinical settings and practices, I also collected data from nurses and physicians in eight individual interviews and two focus groups. These clinicians described what it was like for them to provide sexual health care to young people; they also identified meaningful elements in the care of young people. In my analysis I was particularly interested in the way clinicians framed and constructed young people and their sexuality as one central aspect of the social context shaping the clinical encounter.

Clinicians’ perspectives varied, influenced by the settings they worked in, their individual backgrounds, training, structural constraints of their practice settings, and socio-cultural norms. The common factor across the various perspectives was the clinicians’ shared social location as health care professionals. In most situations, health care professionals are viewed as individuals possessing influence, access to information, and specialized knowledge and skills. Dominant ideas about the clinician as expert, closely related to their aim of managing sexual risk, were reflected in the way they interpreted their social location and in the way they framed and constructed young people.

In considering the significance of the clinicians’ social location as clinicians, I analyzed both the varied and the shared perspectives. From these data I developed two interrelated themes, managing risk and the clinician as expert, which I discuss below. The theme of managing risk refers to what clinicians considered as the central aim of the clinical encounter, and how this influenced their thoughts and actions. This was a theme central to the data about clinicians, and was closely linked with their sense of authority as experts taking the lead in the encounter. The
theme of clinician as expert refers to how clinicians were positioned in the encounter. Clinical interactions depended on and reconstructed aspects of social hierarchy, where the clinician was viewed an expert in the clinician-client dyad, and such interactions also promoted specific perceptions of young people.

**Managing Risk**

The theme of managing risk involved two subthemes: an ideology of young people’s sex as risky, and strategies clinicians employed to manage risk.

**An ideology of young people’s sex as risky.**

Although sexual health is a broad topic, clinicians’ thinking about young people clearly reflected a central focus on risk, and clinical encounters were most often narrowly focused on avoiding disease and pregnancy. Most of the clinicians believed the notion of risk to be central in identifying meaningful aspects of sexual health. For example, Sheena, a physician at the sexual health clinic, said, “I guess the forms [that clients complete about sexual risk behaviours] reflect this in our sexual health clinic, just a vague sense of their overall risk in life.”

Young people, by virtue of their social location as young and sexually active, were often perceived by clinicians as vulnerable to the negative consequences of sex. Alida described what motivated her particular approach to adolescent sexual health:

This group of kids, this age group, is at risk for disease and unwanted pregnancies. Just to try to prevent that from happening to these kids by giving them some information prior to having to deal with those things, which can be devastating.

Potential dangers and problems dominated both the content and the approach to the encounter. This contributed to underemphasizing the positive aspects of sexual health or to
leaving out their promotion all together. When Public Health “as an institution” centers concerns around fertility control and preventing STIs, dangers and disease are emphasized “over sex positivity” (Oliver et. al., 2013, p. 143). Greg, a family physician, and Herda, a sexual health nurse, emphasized that sexual safety and risk assessment were their central priorities:

Greg: I think safety would be the first thing I talk about.

kd: And what would come under your heading of safety?

Greg: Making sure that you and your partner are free of sexually transmitted infections and how to prevent being a victim of those. That’s probably the biggest. Yeah. And how to avoid getting pregnant… That’s probably where I spend my time, having teenagers.

kd: What would you consider to be the meaningful elements of a sexual health visit with youth?

Herda: I guess safety. And I guess in the time that we have with them that’s probably my focus more than anything else. I think there is a lot more that I wish I could explore with them, but I know we are limited with time and stuff, and yeah, so I think it is safety.

kd: And what kind of safety are you talking about?

Herda: Like protection from pregnancy and stuff like that. But as far as, like, decision-making, and protection of their self, and you know, their decisions around sexual behaviour, we, at least I, don’t get into that and I sort of deal with what is there, and so I don’t explore, you know, “Are you ready for this? Do you know how to say no?” I don’t get into that very much. We have short appointments, so it’s like, “Are you sexually active? What kind of sex do you have? You know, so I can do a risk assessment. Do you know this? Do you know that?” kind of thing.

This singular focus on risks and problems or on what might be wrong with the individual person fails to acknowledge the potentially healthy and positive aspects of sexuality. This focus on negative aspects of the sexual behaviour of young people is consistent with the social concern around such sexual behaviour as being risky. Much of society’s understanding of young people’s sexuality is based on social constructions of young people’s sexual behaviour as being dangerous and risky (Bay-Cheng, 2003; Diamond & Huebner, 2012; Shoveller & Johnson, 2006). Within such an ideology, where sex is risky, protecting young people becomes of central importance to
clinical interactions, giving rise to strategies of clinical surveillance and intervention—strategies for managing risk.

**Strategies to manage risk.**

Various strategies employed to manage risk are described in this second subtheme. These strategies included different types of clinical approaches, gendered strategies for managing risk, and silencing sexuality.

**Clinical approaches.**

All of the clinicians interviewed showed both interest in and commitment to working with young people, and viewed sexual health as a worthwhile and important part of their practice. However, there was considerable variation in their descriptions of the care provided, and well as some variation in what they considered to be the meaningful elements of the clinical encounter. In my analysis of the individual interviews, three different types of clinical approaches were described to manage risk. These three approaches differed according to the extent that they reinforced or work against the apparent knowledge/power differences present in the clinician-client relationship (Robertson, 2007).

* a) *Biomedical approach.*

In this approach, medical procedures and physiological processes were the main activities. It was favoured by some physicians in the sample. The primary elements, determined by the physician, could include a physical exam, medical investigations, treatments, and prescriptions of medication. If any brief health education message was delivered verbally, this message emphasized such individualistic notions of risk as, for instance, providing information on condom use, upon which clients could “choose (or not) to act” (Robertson, 2007, p. 45). Other interactions could include medical history taking, or “small talk,” informal conversation
that did not cover any health-related topics, sometimes viewed as a positive contribution towards patient comfort.

Greg described a visit of this type, and explained that his biggest challenge in providing care was making sure that he talked to clients about sexual health: “Making sure that I have done it would be the challenge. Although I suspect I get it in most of the time, but you know, if you were to do an exit poll, it would be interesting to see what the results would be.” John explained that conversation had little to do with his medical visits: “Docs have no time to talk,” because structural constraints related to scarce resources limit what could be achieved. In this approach, the clinician took up a position of authority, delivering the care and information they thought was required. This prescriptive approach reinforced an apparent knowledge/power discrepancy in the clinical relationship (Robertson, 2007).

b) The dialectical (balancing act) approach.

Both doctors and nurses described this approach. A dialectical encounter highlighted a tension between two primary elements of health education: delivering specific risk-reduction information while also advancing a more client-centered approach that considered clients’ needs. Clinicians often described a sense of strain in trying to do both tasks within a single clinical encounter. Beatrice, a clinic physician, explained:

And it’s a delicate interaction, you know. What you were just saying about the younger girls and the pressure [to engage in sexual activity]—so you want to be able to discuss those, but it’s tricky, striking a balance, between coming across as patronizing, just as their mom would be, and open-minded, so that you can actually have a dialogue with them. But you know, kind of striking that balance, raising your concerns without coming across too sort of….
Herda also described this tension between providing health education and providing more client-centered care:

You have them for this little glimpse, and you have all this stuff that you want them to know, and they are not ready to hear it, or they are not there to hear it. You know, you try to give them the little pearl that is all that they are going to take away that night kind of thing. And I guess, not being able to help as much as you wish you could, your agenda being different from theirs… You’ve got all these things that you think they need to know and you think you need to give them, but you can’t…that’s all they have time for, that’s all they have interest for.

In this approach, the clinician was still positioned as an expert on sexual health, with a clear agenda to deliver specific health education they thought the client required. Yet at the same time, this approach shifted towards an alternative position in which the client was accorded some influence in the process of the encounter: information delivery (often unidirectional, delivered from the clinician to the client) might be replaced by “dialogue,” as Beatrice suggested, influenced by client needs or interests. These dialectical approaches held potential to both resist and contribute towards an apparent knowledge/power discrepancy in the clinical relationship (Robertson, 2007). In keeping with the elements of health education described in these first two types of encounters, some providers used questionnaires and checklists to help ensure that specific content relating to risk reduction was delivered.

c) Process-oriented approach.

Some nurses and doctors favoured this approach. The focus and content of these encounters evolved when practitioners established a foundation of relationship and rapport. Meeting young people’s self-described needs was the main agenda. Risk-reduction information
was addressed, but it was to be personalized in terms of the client’s individual situations. These providers avoided checklists and questionnaires, because they felt such things did not complement this style of practice. Tamara explained this type of encounter:

I think if I have definitely established a rapport with them where they then appear … to trust me, to be able to ask questions, to be open, be relaxed, and you can usually see them, feel that, when you’re in a consultation with somebody—I feel that definitely is meaningful and I feel like if I’ve achieved something, so if I’ve helped them, if I’ve done what they want.

The meaningful elements of these visits were identified as listening, detecting, and addressing unspoken client agendas, establishing trust and confidentiality, and providing emotional support. Sufficient time to conduct a visit, recognizing that resources in the system were scarce, was sometimes mentioned as a meaningful element in this type of encounter.

Clinicians who took up this strategy understood it as going against a dominant model of practice. The dominant model of practice, they explained, involved control of the clinical agenda to make sure that specific content was delivered to the client, with the aim of containing and directing their behaviour. Jean, a clinic nurse, explained:

So, meaningful elements for me, one on one, is to get rapport with the patient. I’m there for them, and not pushing my agenda: [not] I have to make sure I tick these things on a box that I’ve talked to you about, you know. For me personally, I go by, I want to see the person, and what brings them here, and also ascertain what they know. So on your little entrance sheet, coming to the reason for your visit it…states that you want to learn more about birth control options. Okay, so yeah, where are you with that? And are you sexually active? And maybe what some of the things are that you might know about it and get
them to help drive the conversation because it’s more about them. And so my meaningful element is asking people questions. And listening. And then seeing how what I know might be able to help them, but it’s never going in and pushing my agenda on them.

This strategy partially challenged the apparent knowledge/power discrepancy (Robertson, 2007) between the clinician and the young person, and had the potential to generate some different relationships and ideas about how the clinical encounter might proceed. Power, to some extent, became dispersed when the client controlled part of the clinical agenda.

Gendered strategies.

Clinicians’ strategies for managing risk were highly gendered, and focused primarily around the provision of care for young women, highlighting some socio-cultural aspects of clinical care. Sexual health care was often conflated with care for young women, “omitting half of the sexually active population” (Saewyc, 2012, p. 1). Young women were sometimes described as needing protection from the risks of sexual activity, reflecting victimizing discourses of female sexuality. Practical reasons certainly exist for clinicians’ focus on women, such as boys’ and young men’s limited attendance for health care, as well as women’s more obvious involvement in pregnancy (Saewyc, 2012). However, young women were also clearly considered in a different way by clinicians than young men were—in these intersections of age, gender, and sexuality, different strategies were employed. Young women were expected to take on more of the “responsibility” for sexual health by engaging in practices to attain or preserve it. Generally, young men were not included in interview data that described clinical encounters, and when they were mentioned, it was mainly in relationship to their limited access to clinical care, or about STIs they might contract or be screened for. In addition, young men were sometimes referred to in terms of an irresponsible approach to their sexual health.
kd: And do guys just not show up?

Alida: I just don’t have young men in my office, to be honest, I just don’t have any… No, I just don’t. Interesting, eh? I did have one young man who came as a boyfriend of another, or a girl in that age group, that started living with their families. The mom asked if I would take him on, which I did. But then when I—he had herpes. And when I told him he had herpes, he never came back. Apparently, he did not like that very much. I honestly don’t know where he is gone, or what’s happened to him.

kd: And would this be partly because of the nature of your practice, that it’s focused on maternity, so you have young families?

Alida: I definitely have moms that bring their daughters once they become teenagers, and say I have doctor so and so, but I really would like my daughter to have a female physician. Whereas I don’t have women doing that with their young men. So interesting…not necessarily the right approach.

Fathers’ potential role in bringing children to the office for sexual health care was not mentioned. Mothers’ responsibilities, or possible mistakes in their approach to bringing their children for sexual health care, were mentioned instead.

John also drew attention to the gendered nature of clinical care. In spite of a relatively recent change at the clinic, to include the care of both men and women, John still saw the clinic as primarily being concerned with the project of controlling women’s reproduction, albeit in a “sort of family planning” atmosphere, reflecting individual understandings of gender, but also social and political understandings reflected in concrete clinical practices and institutions:

It’s effectively a birth control clinic still. Just to give women the pill so that they don’t reproduce, and they can, sort of—family planning atmosphere. We’ve expanded on that to include quite extensive STD screening. It was never like that before. We never had men in before. Now we have men, screening for men and women, and blood work. I don’t think we ever did blood work either, you know, like for HIV, hepatitis, syphilis. That’s relatively new, so we’re expanding beyond the family planning thing to the STD screening thing, for both men and women.
The need to protect young women was sometimes ascribed to dominant assumptions about aggressive male sexuality and passive female sexuality. For example, Penny, a clinic physician in the focus group, commented on a recent news report about the victimization of young girls in their heterosexual relationships: “[It was about] how frequently young girls are engaging in anal intercourse, for example, which is risky behaviour. Feeling compelled to behave like porn stars especially, because that’s what the expectation is. And the damage that does to their self-esteem, I think.”

The clinicians provided evidence that supports a persistence of a gendered division of labour in the maintenance of sexual health. In the nurses’ focus groups at the university clinic, participants related that the nursing care (provided by women) was intended to prepare women for participation in sexual health care practices, care that centered around having a pap test. Betty explained the established norm at the clinic: “For me, we [nurses] hardly, me, I hardly see any males about sexual stuff. For us, it revolves around the female, and the pap prep and all of that stuff.”

Another nurse, Marita, also said she emphasized preparing women for the pelvic exam: she explained the procedures involved, which she understood clients could be frightened about. Nonetheless, these procedures were set out as events that would (should) occur, consistent with social understandings and gendered expectations about female compliance: “This is what is going to happen, and if you are afraid, you can have a nurse, you can have a female doctor.” And Betty says she tells patients, “We want you to leave here feeling good because this [the pelvic exam] is a part of your life, part of being a woman for a long time now, and we want to start off in the right way.” Victoria also described how she prepared and supported women in preparation for the pelvic exam, again emphasizing the necessity of the exam:
I like to relate to them as a woman, not just as a nurse, talking to them. And a bit of mothering, that you can talk to them. This is part of you, it’s just part of what you are going to be doing, and that’s a good way of getting them to relax as well. We are not just doing it clinically, but we are taking that extra moment, connecting.

The nurses and the nurse administrator felt that the nursing activities and conversations described were important contributions to patient care, but at the same time, these activities were also summarized by a nurse administrator in the focus group as “prepping, warming up the patient,” as a prelude to the physician doing the clinical exam. In this context, the terms “prepping” and “warming” might suggest a depersonalized approach to the care of young women. In addition, “prepping” and “warming” could also signal the social devaluation of nurses’ work, as a precursor to the more important work of medical care.

These individual and social understandings that contributed towards the gendered nature of clinical care, including understandings about young women’s greater need for protection from the risks of sexual activity, expectations about young women’s compliance with cervical screening, or notions about their greater responsibility for sexual health compared to young men, are part of a broader discourse perpetuating surveillance, medicalization, and control over women’s bodies (Petersen & Lupton, 1996). Petersen and Lupton have noted how women of all ages have been urged to protect their health, not only in keeping with their own self interest, but also as part of a broader responsibility to others (Peterson & Lupton, 1996). However, these understandings of young women’s bodies as subject to heightened medical surveillance have the related effect of obscuring the young male body “that represents the ‘norm’ and thereby becomes taken for granted” (Robertson, p, 127).
Though young men also have gender-specific needs with respect to clinical care (Saewyc, 2012), these differences were rarely mentioned, and at times seemed poorly accommodated. Some clinicians noted that discomfort could arise in the infrequent event when a young man did present for sexual health care. Ella, a nurse-practitioner student who participated in the nurses’ focus group, mentioned that she had a harder time talking to young men:

It’s the male students who I find it more difficult to initiate that conversation with [about sex], where they have a question and they find it difficult to initiate the conversation with me. So just getting used to when we do see them [men], because it can be very infrequent.

Ella’s comment shows how concrete practices in sexual health oriented towards women, such as the visit for a pelvic exam, or the contraceptive visit, can become almost “scripted” forms of clinical actions and clinical talk, becoming gendered “rituals” that clinicians can rely on. However, when a young man appeared there was no set way to proceed, no automatic set of practices to draw upon, so this infrequent turn of events indeed became something “to get used to.”

**Silencing sexuality as a strategy.**

Power relations shape what is left unsaid in many social contexts. In clinician-client encounters, clinicians who took up positions of authority, working from a belief that the goal of the encounter was risk management, seemed predisposed to focus on certain topics related to sexual health and to omit others. Therefore, topics that were not mentioned, those that appeared to be pushed to the margins in clinicians’ perspectives, especially when these same silences were noted by young people in the study, are as important as those that were mentioned.
Even though promoting sexual health in adolescence requires an understanding of the relationships between relevant aspects of self and the many contexts in which sexual relationships occur (Tolman et al., 2003), topics that relate directly to sexuality were usually avoided in clinical talk. These topics include specific sexual practices, the meaning of becoming a sexual person, gendered identity, sexual orientation, or sexual pleasure and desire as an embodied experience. Consistent with the dominant belief that the goal of the encounter was risk management, the preferred strategy was a more cautionary pedagogy (Addison, 2006). If clinicians interpreted young people’s sexuality as risky and potentially problematic, control or regulation might be called for instead of a focus on sexuality or pleasure.

When I enquired specifically about clinicians’ discussions of sexuality or sexual pleasure, or more broadly of positive aspects of sexual health such as relationships, clinicians usually informed me that such discussions were reserved or only expected to occur in clinical conversations with older people. These older people were often parents who had questions or concerns about their children’s sexuality, or that of married people. Some clinicians simply did not understand my question:

kd: Okay. And does anybody ever ask you for sexual health counselling, about sexuality or sexual orientation?

Greg: Parents. Parents of people do. Yeah, not necessarily, I would say rarely adolescents...Parents might ask me about their children’s sexuality. Older people, talking about sexual pleasure issues—more with older people, I would have to say.

If managing risk is the central goal, concentrating on information to avert sexual dangers not only makes sense, “but appears a prerogative” (Allen, 2007b, p. 578). Conversely, addressing such topics as positive sexuality, including desire and pleasure, becomes problematic. Introducing positive sexuality might even be interpreted as inciting sexual danger, so that education about sexual risk is a more justifiable task (Allen, 2007b).
Later, when we discussed the “ideal visit” in the research interview, Greg mentioned that our conversation had “twigged” thoughts about “things he is probably not doing”—asking sexually active clients questions such as, “Are you enjoying it [sexual activity]? You’re feeling comfortable with it, comfortable with what you are doing?”

Alida also did not enquire about sexual pleasure or sexual functioning with adolescents patients:

kd: Does anyone ever engage with you around things like sexual pleasure or how to make sex better for them and their partners?

Alida: Not in that age group. Definitely in my older women. Not older women, but you know, my married population having kids, for sure. But I don’t think ever in that age group.

In the focus group with the nurses, I enquired about the potential for positive aspects of sexual health to be part of their clinical visit. Their responses also illustrated positive sexual health as an elusive concept in some clinical approaches:

kd: So we have focused our conversation a lot on risks and problems. Do clinicians ever focus on broader sexual health topics? What do you think about that? How might they relate to positive sexual health?

Marita: Do you mean like, relationships? [Nurse’s name] does quite a bit in her [community] education out there…

Peggy: Yeah, and if they are coming in—it may not happen as much when they are coming in for their pap test or an STI test, but if they are coming in because of anxiety or emotional problems, that can be untangled because it might go back to their relationship.

Duncan, a family physician, and Tamara, a sexual health clinic nurse, were the only clinicians who indicated they would talk about sexual pleasure with young people:

Duncan: One of the things I acknowledge, and I acknowledge it with parents in the room sometimes, is that sex is actually a normal, healthy part of life, and it’s a very enjoyable part. The difficulty is that it is clouded by all of the other stuff that happens—fear of pregnancy, fear of sexually transmitted infections, and so on. I’ve got a 13-, almost 13-year-old daughter and I hope that she has a fulfilling, fun, happy, but safe sexual life. And my, her twin brother [name] I want him to have the same sort of thing, a respectful relationship with a young woman as well. And so it’s important to acknowledge that it is
fun. And if you don’t acknowledge that, you are burying your head in the sand, because they are going to do it because it is fun, it’s exciting, it’s a hell of a lot of fun, and extremely pleasurable. So I do talk about that with patients and often bring it up with parents because they don’t sort of see—well, I’m going to sit on the porch with my shotgun and my little daughter is not going to touch anybody. That’s not the reality. The reality is, I don’t care if you grew up in southern Alberta. The reality is she’s going to go out and she is going to do stuff, and she’s going to want to do stuff, but don’t you want her to enjoy it? But, if she’s going to do it, she is going to do it safely and she’s going to arrive home safely. So, yeah.

cd: And do youth ask you questions about how to make sex better for them? That kind of thing?

Duncan: Sometimes I get some interesting questions around the use of dildos and toys and clitoral rings and tongue rings and, you know, those sorts of things, because there is an incredible amount of piercing that is going on.

Tamara said that people sometimes have asked her questions about sexual pleasure and that she answers them, even if, as she hinted, this took some courage because of her unease with sexual subject matter: “I take a deep breath, and then give them the information that they are asking for.”

The Clinician as Expert

Clinicians’ attempts to manage the risks of sex were closely linked with the second theme, the clinician positioned as expert in the clinical encounter. This theme described how clinicians often took the position of experts in their relationships with clients. Clinical interactions provided examples of the clinician taking the lead in the clinician-client dyad and promoted specific perceptions of young people as well as directive approaches in the clinical encounter.

The positioning of the clinician as expert contrasted with how clinicians framed and constructed young people and their sexuality in the context of the clinical encounter. When clinicians positioned themselves experts, they in turn positioned young people as an audience to
benefit from their expertise. Consistent with such a hierarchical arrangement, clinicians often suggested that young people were ignorant or lacked responsibility about sexual health. Alida explains how visits with young people proceed:

I mean I really try to get them engaged, but quite honestly, it’s often me talking a lot and them not saying much of anything. It’s a rare girl that comes really aboveboard and says, “I’m thinking about having sex and I’d like to be on the pill ahead of time.” It doesn’t happen very often. I feel like—I guess I kind of think my role is almost pushing information. I have this opportunity, it’s not very long. I feel like this is like a one time opportunity to get it into their head that this is a big deal.

A lack of knowledge and responsibility about sexual health was also highlighted by John, a clinic physician, who said, “So as soon as somebody gets it, then they ask all the questions they should have asked before they get an STD. ‘How did I get this? What can I do?’” Being knowledgeable and responsible enough would have required due diligence and self-control.

Janet, a university clinic nurse, similarly hoped to cultivate more “responsibility” on the part of young women:

They are being responsible for the decisions that they are taking, and they need to be responsible enough to come in yearly, and so we’re pushing ownership and their pap tests. For them, “That’s your responsibility, not anybody else’s. You have to take care of your body and this is a way you know, that you can protect yourself.

Sometimes young people were not just described as ill-informed or lacking in their capacity to contain and direct their sexual behaviour, but also castigated as irresponsible and selfish, as people who wilfully put others at risk:

Ron: I find it really difficult with that part of the conversation. I find that quite a number of gay men think that an inherent part of it is having many different partners, that is part of it, and if you start to introduce messages about the need for safety and caution, there is a segment of people who just don’t relate to that. It is true on the heterosexual side too. We have the roosters over here who just feel that they are here to see how big a square
they can rack up and that’s that. And they just get turned right off if you say anything at all to suggest that there might be something better they should be considering.

Taylor: Settling down. [laughter]

Bob: I’ve had trouble with those. It’s hard to make a meaningful impact or meaningful change… These people, their safety—I’m thinking of all my other patients who knew this person, in another sense [laughter], and that is difficult.

Apparent power inequities in the clinical relationship were also reflected in the way clinicians guided and directed the clinical agenda. Some clinicians aimed to manage risk in part through their direction of the content and the process of the visit. Sometimes this authority took the form of having a fixed set of topics for discussion, considered as required content, as noted in the following narrative from Duncan, a family physician participant:

I’ve got my “spiel” that I tell them about, date rape drugs, as well—obviously, my female patients. Questions around abortion, drug use is probably one of the biggest things I see. And then the discussion goes into talking about safer sex. And I tell my patients that there is no such thing as safe sex, it really is changed to safer sex. So safer sex strategies, first being abstinent, and finding the right partner. But that is not really a reality, and I know they are going to do something at some point in time and it could be anything from kissing to oral sex, vaginal sex or anal sex, and I’ve got quite a few same sex partners in my practice. And so we see transgendered patients as well. And then from there, talking about birth control, using double methods because birth control obviously doesn’t help with STIs. Using barrier methods, having their partner screened, and then saying they can use my name in vain, that “My doctor says I need to have an STI screening whenever I am getting into a new relationship.”

Alternatively, the content that some clinicians thought should be delivered to the client was more formalized than described above, taking the form of specific sexual health information,
the delivery of which was set out in clinic protocol. John, a clinic physician, expressed his frustration when this protocol was broken due to reduced staffing or clinic scheduling, so that clients arrived in his office for a medical exam without having received, and presumably taken in, the specific sexual health information that was meant to be delivered to them:

So, people—it’s really quite utilitarian. I think what the docs see at [the clinic], by the time they come in, it’s expected they’ve been educated, but sometimes it doesn’t happen. Someone will come in, they are 16, never been on the pill before and say, “Oh I want to go on the pill.” I say, “Did you see the educator?” Because they are supposed to always see the educator. But they say, “No.” So, then I’m putting someone on the pill who doesn’t know how to use it, that statistically has a poor rate of taking the pill, and I don’t have time to talk to her. So what I’ll do is say, “Look, the other choice, see the educator and then see the doctor after, or I can give you…a prescription,” and tell them how to start, but they need to know things like what happens if you miss a pill, what if you miss two pills, what if you miss three pills? What [does] break-through bleeding or spotting mean? This kind of stuff really takes time, and I’ll tell them, I don’t have time to talk to you about any of this. I might give them the handout on it, read it. But I’ll say, see the educator, absolutely for sure, and hope that they do. So then we get hamstrung sometimes by trying to do a service for which someone should have been prepared ahead of time.

Clinicians’ sense of authority, combined with a focus on the responsibility of individuals in determining sexual health outcomes, was sometimes manifest as moralizing about sexual health behaviours. Moral connotations were present, in their simplest form, as judgments around what young people should or should not do. “Shock” or “surprise” was a common reaction when
young people did not do what clinicians would have expected to protect their sexual health.

Alida, a family physician, described this in her clinical encounters with young people:

I always like to know, if they [young women] are active, if they are comfortable having that kind of discussion [condom use] with their partner, and if not, why not? Because I find that fascinating, here we are in 2012. Why aren’t these girls saying, I’m not doing that unless I have a condom? A lot of them still aren’t. I mean, I do spend time exploring that. And then I’m always shocked at how many of them have unprotected sex.

The gender and power relations in which sexual relationships are embedded were absent in the description of the clinical encounters and the role of partners in sex without condoms went unmentioned.

Sheena, a clinic physician, described other challenging aspects of providing sexual health care for young people, and invoked moral judgments about individuals who did not meet her standards for sexual behaviour:

kd: And what are some of the challenging aspects for you in providing sexual health services? Anything that is a little bit harder for you?

Sheena: Just trying to convince some of the, you know, I guess you could call them “repeat offenders,” that some of their behaviour is not going to serve them well in the long term. You know, I just find that really frustrating, I just, you know, want to go, “what are you thinking?” You know, one of these times is it going to be really bad.

Like several other clinicians in the sample, Sheena spoke of her sense of responsibility for directing and containing sexual behaviour and a sense of knowing what was best for those likely to transgress societal standards for safe sexual conduct.

In positioning themselves as someone in authority, some clinicians identified with aspects of parenting roles, introducing role boundary issues that are not usually part of adult clinical encounters. Role boundary issues emerge when therapeutic behaviour is not adequately separated from non-therapeutic behaviour—when clinicians talked to the clients in ways that suggest they
were taking on the role of a parent. For example, Janet, a clinic nurse, described her counselling practices with young women:

They are just starting intercourse and you know, some of their concerns around—well, is this normal to have pain, or no pain, or you know—often I find they have had unprotected sex. And so, I often feel like their mother and start talking about…, have you not learned about, you know, condoms and how to protect yourself? So my spiel about protection is a big thing.

The role-boundary issues introduced when identifying with parent roles may explain in part why clinicians might position themselves as authorities, as parents do. In taking on aspects of parenting roles the clinician may “know what is best” for young people and then feel responsible, or even sad, in thinking about young people’s sexual behaviour. Sheena explains:

It’s still disturbing to me, at the age some of these people start to engage in those behaviours. And I’m thinking there’s lots of time, you know, it might make you do things or restrict yourself in some way because you’re now sort of tied to this person because of these activities that you consider significant. And I feel kind of sad that way.

Summary

The clinical encounters described here were often permeated by concerns about deficits and dangers, the risks associated with young people’s sexuality—a theme that has endured in the public’s conceptions of adolescence. Nurses and doctors took on the work of managing sexual risk, aiming to protect young people and operating within an ideology of risk. They articulated various practices for managing risk, including different types of clinical approaches—biomedical, dialectical, or process-oriented approaches—as well as gendered strategies. The three clinical approaches differed according to the extent that they reinforced or resisted the
apparent knowledge/power differences (Robertson, 2007) present in the clinician-client relationship. Clinicians’ strategies for managing risk were highly gendered, and focused primarily around the provision of care for young women. The clinical talk deployed was not gender neutral. Young women were primarily situated as the ones in need of clinical attention. Related to these understandings about young women, young men and their needs were more tangential, reinscribing a sexist heterosexuality, with young women positioned as vulnerable yet concomitantly more responsible for sexual health. Rather than using the clinical encounter as an opportunity to discuss sexuality in terms of both negative and positive aspects, clinicians often took up authoritative positions, and did not discuss sexuality as part of their strategy in managing risk. Authoritative positions emphasized the social difference between clinicians as experts and their young clients, who were sometimes framed as ignorant or lacking in responsibility for sexual health. Clinicians often used authority to direct the encounter, sometimes moralizing or judging young people or their sexual behaviours.

This analysis is not meant as a criticism of individual clinicians or of different clinical settings. It was clear that clinicians wanted to provide good care for young clients and were working to accomplish the task of clinical care and education about sex in the best way they knew how. Clinicians’ adherence to such a prescriptive model serves as a strong reminder of the strength and persistence of gendered and negative conceptualizations of young people’s sexuality, and a sanctioned clinic agenda focused on managing risk. In the next chapter, where I continue to explore clinical encounters whose aim was to promote sexual health, I focus on the perspectives of young people and their self-described needs.
Chapter 6: Young People’s Perspectives

This chapter is devoted to young people’s perspectives on clinical encounters that aim to promote sexual health. Most participants were keen to be consulted about their experiences in engaging with clinicians and about what they considered to be meaningful elements of care. Their enthusiasm promoted lively discussion in interviews and focus groups. Young people’s perspectives varied according to the nature of their sexual health concerns, their gender, the clinician involved, and the services they received. However, within these variations they shared a social location as sexually active young people—often a site of controversy. The ways young people interpreted their social location revealed that while they experienced judgment, what they wanted was acceptance as legitimate sexual persons.

To understand the significance of their social location, I analyzed young people’s different and shared perspectives, informing my analysis with theoretical ideas about relations of power, gender, age, and sexuality. I developed three interrelated themes: a) participants wanted acceptance but experienced judgment; b) participants had to manage vulnerability; and c) participants believed that positive sexuality matters. The central theme of wanting acceptance but experiencing judgment was closely linked with young people’s vulnerability, a key feature of the clinical encounter; perceptions or fears of judgment could lead to feeling vulnerable. That central theme was also linked to the third theme, that positive sexuality matters to young people. It is only when young people’s sexuality is accepted, viewed as legitimate and positive, that pleasure may become relevant.
Wanting Acceptance but Experiencing Judgment

This central theme conveyed a key message of the young people in my research—they wanted to be accepted as a sexual person and to not be judged. When young people were sexually active, some perceived that their social location conferred particular meanings or led to particular social sanctions in the clinical encounter. Participants who accessed sexual health care made their sexuality visible, and in this more public space sexuality or sexual behaviours might be viewed as illegitimate because of their younger age, consistent with the social constitution of sex as “problematic” or “dangerous,” thereby requiring crisis management (Allen, 2007b). The analysis of both positive and negative encounters with clinicians illustrates the theme that participants wanted acceptance yet experienced judgment. In the discussion below, participants describe some of the different meanings and social sanctions accorded to young people’s sexual activity in negative encounters with clinicians delivering sexual health care.

These negative encounters highlighted participants’ feelings or fears of being stigmatized or judged because they were young and sexually active. In these encounters the young people perceived clinicians to be in roles of authority, with the power to make judgments about what young people should or should not do with respect to sexual behaviour; the clinicians were sometimes viewed as a occupying a “power-over” position in the client-clinician relationship.

For example, Sadie described her family doctor as “serious and scary,” someone who was “going to judge you.” She described that when he asked her if she was sexually active, “he made it seem like something he should not be talking about.”

When you are an adult you are basically allowed to do that [be sexually active], but when you are younger, it’s kind of like, “you shouldn’t be doing that.” That’s the first thing that
is told in my head, because that is what I see, so I don’t really feel comfortable bringing it up because it’s going to be like “well, you’re not even supposed to be doing that.”

Sadie interpreted her social location as a sexually active young woman based not only on social messaging from the doctor, but also on self-imposed judgments reflecting cultural ideals of abstinence for young people. Problematic perceptions about sex can intensify when sexual behaviour is linked with “young people for whom there exists a normative and cultural ideal of being ‘non-sexual’” (Monk, 2001, p. 275).

Asha and Leah also described clinicians’ responses to their requests for STI testing. Leah observed, “The look they give you is ‘Really?’ I just find this very uncomfortable when you have to tell them something like that and they’re just not receptive.” Asha had a new partner, prompting her to request additional testing: “She [the doctor] wasn’t really understanding about that. She just asked me how many partners I had been with, and just like giving me like a judgmental way of saying it.” Asha wanted to be “spoken to in a more understanding way, more than a judgmental way, so that I can say whatever I need to, so how do I say this? So I am not embarrassed to tell the doctor?”

Zara also perceived and yet resisted moral judgments: “You’re just going to try to make us feel guilty about it? That is not going to stop us. It’s just going to make us feel guilty whenever we go to the doctor, you know. That is not encouraging.” She added, “Teenagers know about the consequences of sexual activity, and they [clinicians] continue to shove it in our faces.” Instead of judgments, Zara believed, “They need to be more open and accepting that yes, people have sex.”

These four young women were keenly aware of, yet at the same time resisted, judgments about their social location as young, female, and sexually active people. They positioned the
clinician as someone who had the power to judge them, yet at the same time they did not feel that these judgments were helpful or acceptable. They wanted the clinician to accept them as legitimate sexual persons, but instead they experienced judgment.

Similarly, young men, who were less likely to attend sexual health services than women, also feared the judgment that might arise during a sexual health visit, and they also positioned clinicians as people with the authority to pass judgment on their behaviours. One young man, Wray, said that what frightened him most about making a sexual health visit was not the possibility of being viewed as a sexual person, but instead being judged by the clinician as “a weird sexual person.” Philip described how some doctors had made negative judgments about him. Philip did not trust that clinicians could refrain from these judgments, especially if they were “dickheads”: “I’ve had a lot of dickhead doctors. So I don’t trust them.” Consequently, he no longer attended physicians’ offices for sexual health care.

In contrast, young people who related positive experiences in engaging with sexual health care recalled non-judgmental approaches in which their sexuality was accepted and viewed as a legitimate. Positive experiences and perceptions of non-judgment were linked to specific relational dynamics in the encounter. The young people perceived power as being shared more equally in the clinician-client relationship, creating potential for more collaborative and personal styles of interaction.

Josh explained the importance of “being treated like an equal person,” and Ollie described his positive experiences: “They are listening and calm spoken and yeah, talk to you kindly, still not like in a judging tone or look.” For Ollie positive experiences were possible when clinicians “let them know it [being young and sexually active] was okay, and that they have someone to talk to.”
One focus group participant, Mark, suggested that young men are most comfortable in a sexual health encounter when “the doctor related to them about it, told them a story about their [experience] or something like that. Made it more comfortable.” Eric, another focus group participant, agreed: “Yeah, just bro’ down,” referring to the desirability of straight male camaraderie where interactions are casual in style and power is shared more equally.

Kinga, a young woman, described a positive experience where she was treated as a unique individual: “You don’t feel that you are like no one to them, you kind of feel it is more on a personal level. You are not just another person they have to deal with. They actually try to get to know you.” Another young woman, Katy, said she felt “acknowledged,” known as a person, when she saw a clinician who “doesn’t seem like she’s ever judging me and she kind of like, hears you out.”

One way that young people sought out more positive experiences and non-judgmental approaches was to attend specialized clinic settings. Youth clinics or sexual health clinics were perceived as places where judgments or fears of judgment were minimized and more personal styles of interaction occurred. Leslie emphasized the importance of a non-judgmental approach at the youth clinic she attended:

I think the nurses here understand young people better than a normal doctor would because they just work with youth, they wouldn’t judge you or anything like that. You don’t really want to be talking to some older person who thinks it’s completely wrong for your age to be sexually active.

Maya, a focus group participant, also preferred the specialized setting of a sexual health clinic instead of a doctor’s office because “there’s a lot of posters up even that say like, about different sexualities and stuff, that’s really open to that kind of thing, whereas at the doctor’s office.”
Another focus group participant, Amelia, who also sought services in sexual health clinics, explained further:

When you walk into a sexual health clinic you’re like, okay, pretty much everything I would ask they’ve heard before kinda thing, and they can handle it. When you go to a walk-in clinic or whatever, there is maybe a picture of the digestive system and you are like okay. This is really going to push their boundaries when I ask about dot, dot, dot…

Maya and Amelia’s observations demonstrated the importance of environmental cues in these specialized settings, which let young people know they are accepted and welcomed without judgment. Young people’s desire for acceptance, or their avoidance of judgment, were linked with feelings of vulnerability, a key feature of the encounter.

**Managing Vulnerability**

Those young people who did come for care in that social context in which their sexual activity might be judged as illegitimate described feeling vulnerable. This analysis demonstrates that this feeling was related to power inequities and fears of judgment in the clinical relationship. This theme involves multiple aspects of vulnerability along with strategies for managing vulnerability, which were key to understanding young people’s perspectives. The strategies for managing vulnerability were gendered in nature.

Participants used the word “awkward” over and over again in their descriptions of seeing a physician or a nurse for sexual health services; they also used terms such as “fear” and “embarrassment.” For example, Joey said he found it “awkward” and “creepy” to visit a doctor or a nurse for sexual health care, but he explained that he went anyway: “You need to be able to communicate and carry on.” Wray described what it was like for him to anticipate going to a clinic: “The idea of going to get help with sexual needs somehow is frightening.” When Jack was
asked about how sexual health visits could be made more comfortable for people his age, he said, “I can’t see what would make it one hundred percent better, without it becoming a different situation.” Angela, a young woman in a focus group, also said it was “awkward” to talk about sexual health issues.

In contrast to most participants who described feelings of awkwardness in connection with clinical encounters, some participants described visits as having been “safe” or “okay.” For example, Kinga said, “It’s not like fun, but I mean, I feel comfortable.”

**Multiple aspects of vulnerability.**

Participants described multiple aspects of vulnerability that may be linked to underlying fears of judgment, as they explained what it was like for them to visit the doctor or the nurse. Josh and Ollie highlighted the vulnerability of the exposed self. Josh said,

> It’s kind of awkward because you don’t even know the person and the entire time you are pretty much telling everything you know about yourself… We [young men] don’t like people asking questions. We don’t like people in our face about things.

Ollie said that he could not talk about everything that was on his mind during a clinic visit due to “embarrassment about sharing such a personal story.” He went on to express concerns about privacy that increased feelings of vulnerability, “worry if it will get out, or if something is terribly wrong with you.”

Addicus and Sally expressed vulnerable feelings that made talking about sex more difficult. Addicus said, “You’re probably not going to know what to say to them.” Sally also found conversation problematic:
The whole topic itself is awkward to have to talk about and describe things. It’s not easy. That’s why it is avoided with youth and stuff. They don’t know how to talk about it with someone or describe what’s going on so they usually just leave it.

Cassie described vulnerable feelings that went along with exposing her body during a clinical exam: “The first time I came in for a pap test it was kind of awkward.” The vulnerability of the exposed body was sometimes related to a tendency for some young people to sexualize the visit. For some men and women the sexual health visit represented a sexualized event, highlighting the social meanings that come along with exposing the naked body—the self—a process that was not rendered entirely neutral (devoid of social meaning) even in a clinical examination. For example, Veronica, a focus group participant, explained why she avoided going to her family doctor for sexual health concerns:

Veronica: Also, for me, my family doctor is a 35-year-old beautiful man. [laughter]. So if, I were to ask someone, if they told me to go to my family doctor, I’d laugh at them. I’m not going to talk to him. That’s very uncomfortable for me.

kd: You’re not going to talk to him about sex. Because he’s thirty-something or because he’s beautiful?

Veronica: Because he is beautiful—probably a combination of the two. But for me, that’s why I would never say go to your family doctor. I’d say go to a clinic.

Similarly, other female focus group participants agreed that a pelvic exam done by a man close to their age made them, and perhaps older women as well, feel especially vulnerable and uncomfortable:

Annabeth: It’s a man your age, and to have them down there, I don’t know, it would just be uncomfortable.

Clarisse: Be like, Richard, classmate from ‘87 [laughter]…. Heidi: This is awkward.

Claire: Don’t look.
Many young women indicated a strong preference for a female clinician over a male one. “I definitely need it to be with a girl, like another woman that I am talking to,” reported one young woman. Others said, “I like the doctor who examines me to be a girl,” and, “It is really awkward to describe things to a man.” I noticed that the young women never fully explained the reasons for their gender preference, and I did not immediately question their preference, because we all assumed that their reasons were already understood.

Later, when I asked two participants in another conversation to explain their preference for female clinicians, both said that it was more comfortable to see a woman about sexual health concerns. They said this was because, first, she might have had a similar body or sexual experiences, and second, their perception of the clinical encounter as a sexualized event was diminished when the clinician was female. Susan expanded on the reasons for her discomfort with a male clinician. She interpreted the situation where her body was viewed in the exam room as being not entirely separate from sexualized events where this “normally” occurred:

You think about him [doctor] as a sexual being, you know he is straight, and you think that he can’t completely divorce himself from the sexuality of the situation. Also, I don’t look good enough in this paper gown, and he can’t completely turn off his rating system.

These young women interpreted the clinical encounter as a potentially sexualized and therefore more vulnerable situation, in which she worried about the potential for judgment. This interpretation of the clinical encounter provided an interesting juxtaposition with young men’s perspectives about the social meaning ascribed to the exposed body in the clinical encounter.

Some young men also expressed concerns about being viewed by a female clinician as part of a sexual health examination. Concerns included talking about sex with a female clinician, also in relation to sexualizing aspects of the clinical encounter. Talking about sex in the clinical
visit was problematic for some young men because it was difficult to separate the clinical encounter from their previous experiences in which being touched and talking about sex usually occurred. For example, Donald explained, “If you have a girl doctor, even if she was hot or not, I think you’d get nervous, just from the fact it’s the other sex.” Jeff commented, “I’m just saying you want to keep the guys with the guy doctors talking about sex, and girls with girl doctors, because you got some little guy with cute […], ‘Hey, are you enjoying your sex life?’ No. Like….” Similarly, Trevor worried that if the clinician was attractive to him, her inquiries about his sexual functions might be misinterpreted and understood as sexual advances: “If she’s cute, and she asks you if you are good in bed, you might take it the wrong way.” These comments illustrated how young men also constructed the clinical encounter as a potentially sexualized event, perhaps raising different sorts of concerns, but still further highlighting the multiple vulnerabilities presented in exposing the body and the self in the context of a clinical visit.

**Gender-specific strategies for managing vulnerability.**

Social location clearly affected how one managed vulnerability in the clinical encounter. Young men and women described different strategies in managing their vulnerability in a clinical encounter. However, simply isolating gender from other aspects of identity without considering how such a binary-based understanding of difference might interact would be inconsistent with intersectional thinking. Ideologies of masculinity and femininity, including expected male and female behaviours, together shape young people’s and clinicians behaviours and preferences in this context. For instance, hegemonic masculine representations of sexual health as being a female responsibility can shape the clinical encounter and sustain gendered strategies in the clinical encounter. In a dynamic of both privilege and oppression it is possible to appreciate how these gender “differences” interact fundamentally with each other.
Some men resisted or avoided sexual health care altogether. Alternatively, some young men managed the vulnerability of the clinical encounter by making their visits as brief as possible, to minimize their exposure to a vulnerable situation, by “getting in and getting out” as quickly as possible. In contrast, women in the study described different strategies. They tended to seek out a more personal style of interaction with clinicians to decrease the vulnerability they experienced.

**Men’s strategies.**

*Resisting and avoiding care.*

Sexual health clinicians in British Columbia and elsewhere in Canada see far fewer young men than young women in their clinics, which points to gender-based inequities in service provision (Shoveller et al., 2010). Consistent with these gender-based inequities, several young men in the sample described a resistance to or an avoidance of sexual health care, which they ascribed to their gendered identity. For example, even though Colin attended the youth clinic, he did not “like going to the doctor.” He explained why other men might not be keen to access sexual health care: “Lots of guys are too tough to come in and get help. At least that’s what I’d be assuming, because if not, why would they not want free help?” Devi described how some men think of sexual health as their natural state, so that health care would not easily be perceived as a need: “Lots of guys think they are invincible, because all they got is a dick, and just kind of put it in things, but that is not how it is.”

Some other men in the focus groups preferred alternative sources of information about sexual health over seeking clinical care, “like, there are counsellors for everything.” These alternative sources included counsellors, friends, especially female friends, and family, especially parents: “Parents are probably good, you’re with them most of your whole life so you are comfortable with them.” In addition, some focus group participants identified their female
friends or girlfriends as valued and influential sources of information about sexual health because they felt comfortable with them and knew them well. As Aidan explained,

I think my girlfriend is probably the best person for me to talk to about anything sexual. Because she knows me the most sexually out of anyone. So, I just think it’s the best. She’ll understand the most of it even before I talk to her.

Addicus described his avoidance of sexual health care in his earlier years:

First it was like, I don’t want to talk. Before, [when] I was younger, I had a family doctor and stuff, I still didn’t want to talk about that shit [sexual health] with them. I don’t want to tell you this. I’ll deal with it as it comes.

Some focus group participants made it clear that they would not seek care for sexual health issues. Sammy said, “I wouldn’t see a doctor for any of that shit.” Nick agreed: “Yeah, I wouldn’t, definitely.”

Getting in and getting out.

Another strategy for managing feelings of vulnerability and the “awkwardness” of the clinical encounter was to minimize time in the exam room. Young men tended to characterize the ideal visit by its speed and efficiency, focused primarily on the physical concerns related to STI testing. Michael stated his preference for an efficient encounter: “Pretty much I just want to get in and out of there as fast as I can. I just want them to check me out, you know…” Josh also expressed the same preferences: “Get straight down to business, that’s usually what you came for, yeah, I like to be in and out.” Colin so favoured efficiency and speed that he preferred that the clinician had made preparations for STI testing in advance of his arrival in the exam room: “I like it when they are ready for you to come in already—everything is already laid out, like they
already have all their stuff going and like, they are ready for whatever problem.” He described the advantages of this style of clinical encounter as “quick and easy, kind of painless.”

*Developing relationships: an alternative strategy.*

In contrast to most men in the study, two described other strategies in managing the vulnerability associated with the clinical encounter. Instead of avoiding or resisting care, or making sure to “get in and out” of the exam room quickly, they developed relationships with clinicians, thereby reducing their feelings of vulnerability. Ollie said, “I appreciated them so much…I could talk to them and they, yeah they are really nice, so I haven’t had any real problems.” Addicus talked about developing a relationship with clinical staff: “You know the nurses and stuff, so it has been a lot more chill for me, because then I know everyone working here.” These young men who had developed relationships with clinical staff described an ideal clinical encounter that allowed time for a discussion and a more comprehensive approach. For example, Addicus wanted “to talk about all of it, since I got comfortable with my sexual being.” He discussed his intimate relationships, sexual functioning, physical concerns, libido, and sexual orientation in his clinical visits.

Ollie and Addicus were able to adopt these alternative strategies by virtue of their different life experiences. Ollie, a gay man, and Addicus, a bisexual man, occupied social positions where they could more easily challenge some forms of masculinities and put together their own constructions of what was possible in the clinical encounter.

*The “non-concept” of sexual health.*

The strategies of resisting and avoiding care or “getting in and getting out” were closely aligned with some men’s narrow concept of sexual health. These concepts often centered on problems, and more specifically on physical problems. The following focus group conversation
about sexual health topics suitable for discussion with doctors or nurses illustrates a focus on physical problems:

Aaron: Aren’t those the only three aspects of sex that there are? The sex, the diseases you can get from sex, and the little homo sapiens that come from sex.

Wahej: Well no, you can talk about cleanliness and shit. Like how to take care of your cock, you know?

Emotional or social issues related to sexuality, as opposed to physical problems associated with physiological processes, were often relegated to the realm of the personal, and therefore not viewed as sexual health issues. For example, Nick commented that more complex issues, such as concerns around sexual orientation or relationship issues connected to sexual health, are not “a medical issue, and doctors and nurses are medical people,” so talking to them about these issues would waste their time. Martin also wanted to keep clinic visits focused on physical issues: “My thoughts belong to me, I don’t know, I keep a lot of my thoughts to myself.” For some men, seeking professional help for social or emotional concerns represented an impersonal method of addressing personal issues, diminishing the likelihood that they would be seeking help from sexual health clinicians. For example, Jack said, “The intent of going to the doctor is for clinical help. It’s not for personal troubles, at least in how I approach the doctor. And if I have to go for personal things, then I’m doing it so I can go [get referred] to somebody else.”

Women’s strategies: Establishing connections.

All the women I interviewed sought a process of social interaction with clinicians that was described as less clinical and more personal in nature; they wanted to establish a relationship with their clinicians. Virtue explained that her “really close connection with the nurses and
doctors” at the youth clinic made clinical encounters comfortable for her. Katy described her care at the same clinic:

It is comforting to know that they actually care and can help you, and that’s available to me. I’ve really liked it. I’ve gotten close to [clinician name] and I regularly see her…I talk about my relationship with her. I tell her everything.

The phrase “like a friend” was often repeated when describing the kind of care they hoped to receive. Many young women wanted clinicians who knew them personally, and they wanted to know the clinician as well. Wren, a focus group participant, explained that “then they just understand. They’ll talk to you. They’ll joke around with you and they will just treat you like a friend, and not your patient, I guess.”

These young women appreciated clinicians who shared aspects of their own experience as part of the clinical interview, and related this experience to the client’s situation. In an interview Kinga described how her ideal visit involved a clinician who aimed for emotional reciprocity and emotional engagement:

Someone as well who is kind of not afraid to give you experiences from their past.

Someone who is kind of willing to sort of meet you half way, where you’re like, “well, I’m going through this and this,” and they can be like, “either I’ve been through this as well, so I kind of know,” or “like I’ve seen my friend go through this,” and just someone that can relate to you as well.

In keeping with their preference for developing a relationship with their clinicians, participants expressed a desire for continuity of care, so that they would not have to rebuild rapport with every visit. Cassie described how she liked to get to know the clinician: “Seeing the
same person and being there on a regular basis in case you need them is really helpful.” Sally also described the benefits of an ongoing relationship:

I’ll see the same nurse and doctor every time I come here. So it’s easier for me to describe to them, whereas if I come and they are on vacation or they are not here, it’s really hard for me to usually bring it up—topics. I usually end up leaving it until I see my nurse or doctor when I come back.

In focus groups, some women expressed the need for supportive and personalized care that was linked to their preferences for nursing care over physician care. “I have to say I personally prefer talking to nurses than doctors about things like this [sex],” said one woman. “[Doctors] just look for what is wrong,” another woman observed, and “ask, like, are you sick? That’s what I need to know. How can I fix you? Stuff like that…Nurses are focused on the care, the, well, mental.” The nurse seemed to be much more approachable. One woman said that “the nurse who brings you into the doctor’s office…I’d much rather chat with her for 30 minutes than talk to the doctor.” “It’s like when you go to the hospital even for something minor, or fell off your bike or anything really…you’d prefer talking to the nurse.”

These perspectives suggest that a focus only on pathological processes, on “what is wrong,” might provide an inadequate understanding of women’s sexual health practices in their everyday lives. In revealing their preference for nursing care, the women reinforced their preference for relationships and conversations with the clinician about their experiences and their social context. The women experienced their sexual health needs as closely linked to their emotional needs and consequently, they valued the ability to relate in professional caregivers.

Women’s preferences for supportive and personalized care also informed their preferences regarding clinician characteristics. In seeking to establish a relationship with
clinicians, some women preferred someone of the same gender and of a similar age: “When someone is a little closer in age they can kind of relate to what you’ve been through, because they’ve kind of been through the same almost.” Participants wanted a “woman doctor, also having someone close to your age […] If you go to a clinic usually you’re going to get a nurse or a doctor that’s younger.”

When young women described supportive and sex-positive care, they talked about a comfortable relationship in which their sexuality was accepted, so that pleasure, desire, and relationships could become relevant.

**Positive Sexuality Matters**

The discussions about how positive sexuality matters revealed areas of concern beyond fertility control and STIs. Young people had questions about pleasure, desire, relationships, and the logistics of sexual practices, but fear of judgment was often a barrier to asking such questions. In fact, young people preferred that clinicians take an active role in initiating these discussions; as one person said, “That would be hugely beneficial.” Others said that “it would be important for the doctor to bring that up,” and that “it is relieving to be able to discuss it with someone that understands and can help you with what you need to know.” They expected the potential content of clinical discussions to include information on contraception and STI prevention, but they mentioned that other positive aspects of sexual health, such as sexual pleasure, were important, yet were missing in clinical conversations. Even if a young person did not want to talk about sexual risks and pleasures in a particular clinic visit, they wanted to be asked.

According to Melanie, clinicians always leave positive aspects of sexuality out of their discussions:
When it comes to sex for girls they should really talk about how to make it good. Because it takes some effort to figure that out... I find the last thing the doctor wants to talk to you about is how to make sex good.

Zara also noted that much attention was accorded to negative aspects of teenage sex, such as unwanted pregnancy and STIs, but she noted that the clinical encounters did not include talk about positive things: “They don’t talk about sex like making love. They’re like, it’s sex. That’s what it is. It’s like, ‘well, no.’” The emotional and positive aspects of the experience had been left out. Zara thought that the lack of discussion of pleasure was related to a clinical focus on messages of regulation and control:

No one talks to teenagers about that because they just think about the fact they should not be having it. They don’t think about the fact that they are having it… If you don’t, it’s kind of going to screw over the teenagers.

Tina also pointed to the missing elements of sexual pleasure: “It’s kind of like, they send you out the door, like, be safe. Don’t get pregnant. Don’t get herpes. Stuff like that. Don’t enjoy sex.” Martha and Jean also explained that positive aspects of sexuality and pleasure were areas in which they wanted support or guidance:

Martha: I think also back to the doctor question, when you go, you just have questions about your sex life and stuff, even if it’s not, am I doing this wrong, it’s like also, am I doing this right?

Jean: Yeah, it’s a concern.

Heidi described her keen interest in putting positive aspects of sexual health on the clinical agenda:

The biggest health concern or anything to do with my physical health is probably related to my sex life, unless I have an alternative, another issue. So I feel like there should be more time focused on that because I really feel if it’s skimmed over and I mean, I really
don’t have any other medical issues to deal with other than my sex life…That’s where all my questions usually lie.

Some young men also wanted to discuss positive aspects of sexual health. For example, Stephan, a participant in a focus group, noted, “I think that stuff [sexuality] is good to talk about.” Roman agreed: “I’d want to figure out how to help me. If I have to talk to my doctor about a way to make my sex more enjoyable, I’m going to do it.” Ollie thought it was good to discuss sexuality in clinical conversations, “because talking about it makes you more sure of yourself.” In addition, he noted that when clinicians were aware that “people need to have someone to talk to about that, and they are there for that, that’s really cool.”

In contrast to the majority of participants who thought that positive aspects of sexual health deserved a place in clinical conversations, a few young people in focus groups disagreed. For example, one young man observed, “I feel like the doctor’s office is a place where you go when things are going wrong with you… I go to a doctor if I have pneumonia or something.” Another young man explained that he reserved clinical visits for sexual problems that he could locate in the realm of the physical body, “probably for something like blood in my urine or some infection or boils or something.” One young woman observed that her questions about pleasure “are more put in Google,” rather than topics she deemed suitable for clinical conversations.

Gender affected how people thought about conversations on pleasure and positive aspects of sexual health. While most young men agreed that it was positive and desirable for clinicians to initiate conversations about the positive aspects of sexual health, sometimes men were less than sure about how these conversations might have personal relevance. For example, Michael said, “If I knew I could [talk about sexuality], I would be a lot more open about myself;” yet at the same time he assured me that there were no issues that he needed to discuss: “Like I got a lot of
sex. I’m good to go on that stuff, you know…” Devi wanted to be asked about sexual functioning, but at the same time he also assured me that “everything is fine with me,” which is normative masculine sexual health behaviour. The young women, however, wanted to talk about “when you should have sex.” Harriet had specific questions relating to her family—”how to get your parents to accept that you are having sex.” The men believed that positive sexuality should be discussed, but actually asking about a personal issue was harder to envision. Needing to ask for sexual health information was not comfortable because young men are assumed to have mastery of sexual health information by virtue of being male (Gahagan et al., 2007). In contrast, most young women easily and clearly identified information gaps and needs relevant to their own situation, further illustrating the gendered nature of help-seeking behaviour in this context.

**Recommended content for sexuality discussions with clinicians.**

Over the course of the study I kept a list of sexual health topics that young people deemed appropriate for discussion with clinicians. In focus groups and interviews, young men recommended a variety of topics they had discussed, or would like to discuss, at clinical visits. These included contraception “as a male thing”; sexual orientation; sexual pleasure and sexual functioning; relationship issues, including female perspectives; alternative sexualities; and growth and development; sex drive; and pornography. For example, Jack wanted to make sure that misconceptions about pornography were addressed, since he found “that it is just some story” that had failed to correspond with his own experiences. Ethan, a focus group participant, wanted to talk about his difficulty controlling erections and the negative impact this had on his intimate relationships: “It is kind of frustrating… The intentions of the situation, to her, are changed.” Christopher wanted to talk about “the psychological effects of a bad relationship.”
Young women, who preferred to engage and develop relationships with clinicians, described an even broader variety of topics that they identified as appropriate to discuss with clinicians. Often they described concerns or questions about physical pleasure that they had never mentioned in clinical consultations. Sadie wondered, “How am I supposed to feel, for me? Because I know how it is supposed to feel for him.” Stella wanted to ask questions about her sexual response, like “when you think it would be better than it is, but it is really not.” Sasha, a young woman in a focus group, said that she would really like to be able to ask about her experience with specific sexual practices, “so then you could say, well, is that all there is? Like really? It would be very handy to be able to ask these kinds of questions.”

Other questions that women raised were related to their intimate relationships, including how to accept or refuse sex—how to negotiate sexual control. For example, Lynne wanted to talk to a clinician about times “when you are with a guy, you feel pressure to do certain things and those for sure are sometimes taboo, even for talking with your friends.” Freya thought that sexual health clinicians should ask about “the mental health side of things”:

If you are respecting your partner and your partner is respecting you. Or if you, like, fear, like, there is any sort of violence or anything like that because, or…even, like, manipulation… You’re being like forced to have sex with your partner, you don’t want to be….

Women in focus groups generated an extensive list of psychosocial issues deemed suitable to discuss with clinicians. The list reveals many missed opportunities for clinicians to provide guidance and support in promoting sexual health:
• Sexual functioning—how to have orgasms and how to “make him last longer”; low desire; specific sexual practices (“Am I doing this right?”; “Is this normal?”; “Am I normal?”; “How do I do this?”)

• Assessing readiness for sexual involvement

• Relationship issues influencing sexual health—dealing with pressure to try different sexual practices; sexual consent; communication strategies with partners and parents

• Encouraging men’s involvement in sexual health

• Conversations that decrease the stigma around sex for girls

• Sexual abuse and exploitation

• Sexual orientation

• Gender identity

Participants also identified alternative sources of sexual health information: internet resources, friends, family, counsellors, and “romance shops.”

**Young people’s suggestions for clinical questions.**

When young men and women recognized their sexuality as legitimate and positive, they wanted to discuss how pleasure might be addressed in the clinical encounter. They suggested ways in which clinicians could improve their assessment practices, such as how enquiries might be made, as well as specific clinical questions.

Their ideas about how information might be discussed differed, however. Some young women thought that a questionnaire would be a good way to collect information and assess concerns before each clinical visit: “Stuff like, how is your relationship? Is it healthy? And stuff like that.” Other young people thought asking clinical questions to encourage discussion would be better. Some young people preferred general questions, such as, “How is your sex life?”; “Is...
your sex life currently enjoyable?”; “Do you enjoy sex?”—enquiries aimed to open communication. They advised that these types of enquiries could be successful as long as the clinician established a context for the discussion: “Out of nowhere might be a little awkward.” To establish this context, the young people suggested that clinicians could remind or inform clients that part of their clinical work was to be a resource for discussions regarding sexuality, affirming that these discussions were a routine part of care, “a normal thing.” Angie noted, “It’s not expected, and traditional doctors obviously don’t talk about that stuff, so space needs to be opened up before it can happen.” Other participants preferred the clinician to ask more questions, as well as more specific questions. Hanna advised, “The more specific the question, the more depth you have.” Safia said, “More specific questions would be easier to answer.”

Finally, some focus group participants noted the value of placing visual cues in the clinic environment relating to sexual health. Yelena suggested “some signal that it’s okay to talk here. You can ask questions if you have them.” She cited the slogan, “We won’t get weird,” used in the Options for Sexual Health poster campaign. Claire noted that posters in medical offices could indicate that, “if you want to talk about sex, you can ask us, some kind of slogan.”

Summary

Young people expected yet resisted judgments about their social location as young and sexually active people. They emphasized the importance of non-judgmental approaches where power was shared more equally between themselves and the clinician, because such a relationship created the potential for collaborative and personal styles of interaction. Accordingly, young people navigated the health care system seeking out specialized clinic settings perceived as offering non-judgmental care and more personalized and sex-positive approaches indicating acceptance of youth sexuality. Young people who did come for care
described feeling vulnerable. The analysis indicated that feeling vulnerable was related to perceived power inequities and fears of judgment in the clinical relationship. These feelings of vulnerability were key to understanding young people’s perspectives on the clinical encounter in which the body and the self were exposed. Participants described gender-specific strategies for managing vulnerability. Young men resisted or avoided care, or reduced exposure to vulnerability by “getting in and getting out” of the exam room. Young women described different strategies, including seeking out personalized and warm relationships with clinicians, and a preference for continuity of care. When the clinician viewed young people’s sexuality as legitimate and positive, pleasure became relevant. Young people often described positive aspects of sexual health, such as sexual pleasure, sexual practices, relationships, and emotions related to sexuality, as important yet missing elements in clinical conversations. To this end, young people recommended specific content and clinical questions about these positive aspects of sexual health, suggesting many missed opportunities in providing them with guidance and support in making healthy decisions about sex and sexuality.
Chapter 7: Enhancing Equity in Practice and Theory

In this final chapter I consider the ways in which the study methods and findings can enhance research, clinical practice, and theoretical understandings of sexual health, with the goal of enhancing sexual health care for young people. Toward this end, I focus on the discrepancy between young people’s perceived needs in the clinical encounter and what they actually receive, revealing how social context has shaped clinical encounters about sexual health generally, and this discrepancy in particular.

The chapter begins with an overview of the findings, situating them within the existing literature. I outline the discrepancy between young people’s wants and needs and what they are actually offered within a social context that shapes their opportunities for sexual health. Next, I describe how the social context that shapes clinical encounters about sexual health presents specific obstacles towards change. The chapter ends with a discussion of implications for nurse researchers, the strengths and limitations of the study and some suggestions for clinical practice, but also touches on education, and policy.

Review of the Findings

The clinical encounters described in this study demonstrated a focus on concerns related to deficits and dangers consistent with the social construction of young people’s sexuality as problematic or risky. In keeping with that ideology of youth sex as risky, nurses and doctors took on the work of managing risk to protect young people. When managing risk, clinicians used a variety of strategies, including different clinical approaches, gender-specific strategies, and the silencing of sexuality. The work of managing risk was closely aligned with clinical authority and taking the lead in the clinical encounter. When clinicians positioned themselves as sexual health
experts, they in turn positioned young people as the audience that might benefit from their expertise, which ensured an adherence to more prescriptive clinical agendas. These prescriptive agendas included moralizing and judging, as well as directing the encounter to deliver health information for the purpose of averting sexual risk.

Agendas focused on risk management were quite often the antithesis of what young people wanted from the clinical encounter. Young people described that in some encounters, they wanted acceptance but experienced judgment. Positive experiences, more in line with the needs young people expressed, involved being treated as an “equal person” known on their own terms. Instead of looking for risk managers, young people expected respect and non-judgment, valuing those clinicians who got to know them as individuals. Young people who did come for care described feeling vulnerable. In my analysis, I identified these feelings of vulnerability as being related to apparent power discrepancies and fears about being judged by clinicians. Young people also described gender-specific strategies they used to manage vulnerability in the clinical encounter. Young men often described resisting and avoiding care, or reducing exposure to vulnerability by “getting in and getting out” of the exam room. Young women sought personalized and warm relationships with clinicians, with a preference for continuity of care. These young people understood sexual health to be not just about disease control and pregnancy prevention, but also about pleasure, desire, and healthy relationships. In contrast to the dominant negative conceptions of sexual health, positive aspects of sexual health were often described as important yet missing elements in clinical conversations; young people were not asking the questions to which they needed answers. To this end, in our discussions, young people suggested approaches that treated sex as a positive thing, or “sex positive”: accepting the sexuality of young people as a significant and healthy part of development would improve their sexual health
care experiences. In sum, the discrepancy between clinicians’ perspectives and young people’s perspectives regarding the power relations and the processes of the clinical encounter signaled a significant discrepancy between young people’s self-described needs and the clinical encounters they actually received.

The clinical settings were more than just places where care was provided. Analysis revealed that in the time and space of clinical locales were manifest the larger systems of social differentiation, political power, and material production (Poland et. al., 2004). Within the power relations embedded in space and place, young clients were either marginalized as “add-ons” in the larger project of providing health care or alternatively rendered invisible within the more visible categories of adults or children. Even in alternative clinical settings whose purpose was to serve this population, while young people were honoured as young people, they were nevertheless kept in their “place” through spatial arrangements both illustrating and sustaining power relations, thus differentiating clients from providers.

**Discrepancy Between Perceived Needs and Clinical Encounters**

In this study, I examined the gap between what young people wanted and the clinical encounters delivered to them by comparing and contrasting the themes found in clinicians’ perspectives with corresponding themes found in young people’s perspectives. Although at first glance they may seem quite different, clinicians’ and young people’s perspectives could be viewed as representing opposite sides of a single coin, and therefore, very closely related in some ways. In situating the findings of this study in the wider body of literature, “both sides of the coin” were held up for closer inspection. This inspection revealed that the discrepancies between what young people want and what is delivered to them might influence care. In particular, the following tensions were noted: a) clinicians managing risk, in opposition to young people’s
views that positive sexuality matters; b) clinicians as experts, in opposition to young people wanting acceptance but experiencing judgment; and c) clinicians’ gender-based strategies for managing risk, in opposition to young people’s gender-specific strategies for managing vulnerability.

**Risk management versus positive sexuality.**

In keeping with society’s prevailing ideology that the sex young people engage in is risky, clinical approaches described in this study, as well as in the broader sexual health literature, are commonly focused on strategies to manage risks, with the goal of promoting sexual safety. Shoveller and Johnson (2006) observed that risk management, intent on improving individual teenagers or their behaviours, has been the usual approach to dealing with the problems of young people’s sexual activity. Oliver et al. (2013) also noted that public health, as an institution, has focused primarily on managing danger, disease, and fertility rather than adopting such sex-positive approaches as discussions about positive aspects of sexual experiences that take into account pleasure and desire. Indeed, it may be argued that negative conceptualizations of sexuality, which justify clinical agendas focused primarily on managing risk, have often been the default presumption in clinical health practice. While many scholars have challenged this primary focus on risk (Addison, 2006; Bay-Cheng, 2003; Macleod, 2009; Schalet, 2011a), it has taken thirty years for family planning programs to begin to promote the potentially positive role of sexuality in clinical practice and to address sexuality as part of reproductive health care services (World Health Organization, 2006).

When people’s sexuality has been viewed as problematic, requiring management and containment, studies have shown that young people, especially girls, have had to submit to social control and restriction (Oliver et al., 2013; Bay-Cheng, Livingston & Fava, 2011). My study
revealed an ideology among clinicians of youth sex as risky that is consistent with current and dominant discourses about young people, in which the social constitution of their sexuality as “‘problematic’ and ‘dangerous’” requires management. This finding has been reported in several other studies concerned with youth and sexual health (Allen, 2007b; Bay-Cheng, 2003; Macleod, 2009; Schalet, 2011b; Shoveller & Johnson, 2006). Clinicians’ primary focus on the prevention of diseases and pregnancy can reflect broader social concerns in Western societies about risk (Allen, 2007b). In accordance with these broader social concerns, clinical encounters have also become risk-conscious events consumed with young people’s safety and shaping clinicians’ approaches to sexuality.

In this study, I have shown that clinicians used various strategies to manage risks: different types of clinical approaches, gendered strategies, and silencing sexuality. The literature about clinicians’ perspectives in providing sexual health care to young people is limited (Masaro, Johnson, Chabot, & Shoveller, 2012), so these different types of strategies in managing sexual health risks have not been previously described in this particular way. In this sense, the strategies described in the current study are novel findings and extend the literature. However, aspects of the three different clinical approaches, the biomedical, dialectical (balancing act), and process-oriented, described in Chapter Five, do reflect familiar debates, particularly about prescriptive medical models of practice versus more relational approaches, such as client-centered care that emphasizes respectful and responsive approaches in which clients often take the lead (Registered Nurses’ Association of Ontario & Canadian Electronic Library (Firm), 2006).

The finding of the current study that identifies the silencing of sexuality as a strategy in managing risk has been at least indirectly reflected and supported by the clinical practice literature that consistently documents distressingly low rates of sexual health counselling for
young people (Flicker et al., 2009; Marcell & Ellen, 2012; Rand, Auinger, Klein, & Weitzman, 2005). A common clinical approach to youth sex and sexuality is to not talk about it, since many clinicians feel discomfort about or are ill-prepared for discussing sexuality with young people (Banter, Brey, Clark, & Khubchandani, 2012). Silence as a strategy in managing risk has been mentioned more specifically in the sexual health education literature. In an environment of repressed sexuality, talking about pleasure is usually avoided (Oliver et al., 2013) and might even be viewed as promoting sexual activity and, consequently, sexual danger (Allen, 2007b).

Contrary to agendas focusing on risk management, young people favoured a more comprehensive approach to care, one in which positive sexuality mattered. Young people in this study expected and appreciated health-promoting information whose purpose was to reduce the risks associated with sexual behaviour. However, many took issue with the sometimes moralistic presumption that the only health-relevant aspects of their sexuality concerned its potential for risk. This study’s findings suggest that positive aspects of sexuality, and not just sexual risks, had a significance and relevance in the lives of the young people in the study that was not often acknowledged in the clinical encounter, and they wanted this to change. Therefore, participants viewed clinicians as having the potential to fulfill broader roles beyond managing risk that could include education and guidance about a variety of aspects of their sexual lives, including building healthy relationships and teaching them the skills required to have safe and pleasurable sexual experiences.

The study findings, indicating that positive sexuality matters to youth in the clinical encounter, are consistent with other research on young people’s self-described needs in sexual health education. The extant body of literature on young people’s self-identified needs in sexual health education in school- and community-based settings is now growing, and the current
findings add to and correspond with this body of literature. For example, Flicker et al. (2009) also identified discrepancies between what young people are learning in sexual health education and what they want to know. Young people in this community-based study, done in Toronto, Canada, identified “healthy relationships, HIV/AIDS and sexual pleasure” as the top three sexual health topics (Flicker et al., 2009, p. 6) that they wanted to learn more about. Other Canadian youth in British Columbia, in the small community of Fort St. James, also requested less focus on abstinence and “fear-based” content in their sexual health education (Soon et al., 2009). Youth in the province of Nova Scotia, Canada, reported that sexual health education in their schools lacked relevance and seemed out of touch with their subjective experiences (Langille, 2000). Senior students in New Zealand also indicated that their primary concern was to know more about ways to make sexual activity enjoyable for them and their partners (Allen, 2005). In a similar vein, young people in the United Kingdom expressed needs for more comprehensive sexual health knowledge, especially around forming and maintaining relationships. They requested guidance in managing specific relationship issues such as infidelities, love, jealousy, and sexual attraction (Forrest et al., 2004). They wanted to know about sexual logistics, masturbation, and sexual orientation. Several other researchers have found young people consider that a discourse about desire is missing in their sexuality education (DiCenso et al., 2001; Fine & McClelland, 2006; Ingham, 2005).

This research shows that in many countries, interest is growing about the discrepancies between what young people want to know and what is offered in school-based sexual health curricula (Abel & Fitzgerald, 2006; Allen & Carmody, 2012; Hillier & Mitchell, 2008; Hilton, 2007; Rolston, Schubotz, & Simpson, 2004). Young people across a range of countries have consistently identified what they want to know, as well as topics that are over-emphasized and
those that are omitted in sexual health education (Allen & Carmody, 2012). Areas that are omitted include pleasure and desire, as well as emotional aspects of sexual experience, while reproduction and negative sexual health outcomes, especially for young women, are emphasized—pregnancy, abortion, and sexually transmitted infections. In addition, sexual health education approaches were also criticized for their focus on vaginal-penile intercourse, avoiding a broader and more inclusive range of sexual behaviours and experiences.

However, little research has been conducted asking young people about their self-described needs regarding sex-positive approaches in the clinical context. Therefore, the results of this study are consistent with and contribute to the small number of findings in this area of the literature. As in this current study, other researchers have noted that young people see nurses and physicians as potential allies in teaching the information and skills required to negotiate healthy and pleasurable sexual encounters (Banter et al., 2012; Brown & Wissow, 2009; Frappier et al., 2008; Gahagan et al., 2007; Oliver et al., 2013). For example, in a recent study by Oliver and Cheff (2012), eight young women who were homeless suggested that sex-positive clinical care, as opposed to care delivered with an emphasis on negative and feared outcomes, would help allay anxieties and establish a more comfortable setting for asking questions and getting treatment.

Findings from the current study indicated that young people did not directly ask clinicians questions about their sexuality. Participants wanted clinicians to initiate discussion on sexual health topics, and this finding is consistent with previous research about young people’s preferences (Ford et al., 1996; Langille et al., 1999; Soon et al., 2009). Since relatively little research has focused on young people’s self-described needs in clinical consultations promoting positive sexual health outcomes, the findings in this study provide some new contributions to the
literature. In particular, young people in this study offered valuable insights about how clinical questions about positive sexual health might be framed in the context of the encounter, and what specific questions might be asked. Also, the specific topics that young people would like to discuss in the context of sex-positive consultation have not been extensively described, so the topics described here not only extend the literature, but also contribute specific information about the unique needs of some youth in an urban centre in British Columbia.

**Judgment versus acceptance—clinician as expert.**

Power relations in the physician-client relationships, another factor in the discrepancy between what clinicians provide and young people want in sexual health education encounters, have been assiduously critiqued over a considerable period of time in the literature (Nettleton, 1995). As in the current study, most of this literature has focused on the power differential between the clinician and the client, on the “dominance and precedence” (Robertson, 2007, p. 6) of clinician perspectives over client perspectives about health. Therefore, the theme of the clinician as expert is consistent with and supported by an emphasis on hierarchical power relations in the physician-client interaction that has been previously described in other broader health contexts.

Despite the growth in clinical services related to sexual health, little is known about clinicians’ perspectives on providing care to young people (Masaro, Johnson, Chabot, & Shoveller, 2012), and more specifically about how these clinical encounters are situated within relations of power. Therefore, the current study offers new insights about clinical encounters where clinicians sometimes positioned themselves as experts, in turn positioning young people, an audience sometimes represented as irresponsible or ignorant, as the beneficiaries of their expertise. Moreover, clinicians sometimes described taking the lead in the clinical encounter,
moralizing or judging, and taking on aspects of parenting roles, thus establishing aspects of a hierarchical relationship. Taking on parenting roles in the clinical context can inappropriately blur professional boundaries—a misuse of clinicians’ power. Taking on parenting roles in this context has not often been described in the literature. However, one recent study on provider’s views regarding their provision of STI services to young people is consistent with and supportive of the current study findings. As in the current study, Masaro and colleagues also noted how clinicians sometimes take on parental roles, thus overriding “young people’s agency” (2012, p. 5). Also in line with results of the current study, they reported that STI service providers also employed specific strategies because they had a sense of knowing what was best for clients, part of their taking on parental roles. Another intriguing parallel between the results of the current study and the work by Masaro et al. is that the service providers also attributed STI care difficulties to young people’s alleged irresponsibility, emphasizing a social difference between them and their young clients.

In contrast to the assumption that young people are looking for experts to take up positions of authority, young people in the literature and in the current study described wanting acceptance from clinicians. Though the literature has often identified a simple dualism of a powerful clinician and a passive client, young people in the current study described a more nuanced version of power relations. In this study clients anticipated yet also resisted clinicians’ judgments about them and their behaviours, and they showed a preference for clinical interactions in which they were treated more equally and respectfully. Robertson has also described how apparent power inequities in the clinical relationship may be complicated by “acts of resistance” (Robertson, p. 6), which also characterized young people’s perspectives in the current study.
In line with their preference for more equality in clinician-client relationships, clients were also looking for attitudes of respect and non-judgment from service providers. As in Oliver and Cheff’s study, the clients in the current study described the most desirable sort of care as a situation in which power relations are more dynamic, where clinicians see their relationship with clients “as an exchange rather than a monologue” (Oliver & Cheff, 2012, p. 375). The emphasis of young people on respect and non-judgment in the current study is an almost universal refrain in the literature about young people’s perspectives and needs (Buzi & Smith, 2013; Ensign, 2001; Lys, 2009; Oliver & Cheff, 2012). Consistent with the results of the current study, young people want clinicians who do not talk down to them, but rather who accept them as sexual persons without appearing to judge (Ayala, Hewson, Maldonado, & Palagina, 2008; Flicker et al., 2009; Frappier et al., 2008; Ginsburg et al., 2002; Shoveller et al., 2004).

Wanting to be known as individuals, which appears to be part of wanting acceptance, suggests an interaction in which the clinician acknowledges the young person’s personal and social context. The desire to be known as an individual in this specific context has not often been emphasized in the literature. However, in Cheff and Oliver’s (2012) and Ensign’s research (2001), similar aspects of good sexual health care are described as the result of cultural competence. In good sexual health service provision, culturally competent clinicians listen to clients, according value to their life experiences and individual stories, which then become included as part of the assessment and treatment plan (Lys, 2009; Oliver & Cheff, 2012).

Rather than displaying attitudes of shamelessness or disregard consistent with ignorance or irresponsibility, the young people in this study appeared to care very much about how they would be evaluated by clinicians. Moreover, they described the clinical encounter as a situation in which they felt quite vulnerable. These findings support and are consistent with other research
suggesting that fear, shame, discomfort, or worries about being judged served as barriers to communication with clinicians about sexual health (Ayala et al., 2008; Buzi & Smith, 2013; Fallon, 2013; Lys, 2009; Oliver & Cheff, 2012; Soon et al., 2009), preventing access to clinical services and limiting discussion about their concerns and questions.

*Gender-based strategies for managing risk versus gender-specific strategies for managing vulnerability.*

Clinicians in the current study often described the provision of care for young women, often ignoring or focusing to a lesser extent on the clinical care of young men. This focus on women is considered as normative in sexual health education in Canada (Gahagan et al., 2007). Reflecting these socio-cultural norms, clinical talk in the current study was highly gendered, revealing an understanding of sexual risk based on gendered stereotypes. Young women were perceived to be both more vulnerable to the risks of sexual activity yet concomitantly more responsible for maintaining sexual health, a perception that perpetuates gender inequities. In keeping with these gendered understandings, there was no evidence that masculinity and gender as fundamental concepts in the planning and delivery of clinical care were incorporated in the clinical encounters described here; young men’s needs were diminished or sometimes ignored. In addition, clinical discourses of female victimization and disease based on gendered stereotypes offered limited subject positions for both young women and young men.

Clinicians’ gendered understandings of sexual risk described in the current study represented and sustained sexist and heterosexist discourses of female victimization and disease already familiar in the literature (Bay-Cheng & Lewis, 2006; Gahagan et al., 2007; Saewyc, 2012; Tolman et al., 2003). In spite of the familiarity of these discourses, the findings of the current study offered new insights about some ways these gendered understandings were
reflected in clinicians’ perspectives and how these understandings influenced the way clinicians provided care. While clinicians continue to rely on gender-based understandings of sexual risk, they cannot begin to develop more effective clinical interactions to engage young people or address the complexity of diverse perspectives.

Young people’s perspectives on the clinical encounter were also highly gendered, but in contrast to clinicians’ perspectives, they highlighted gender-specific ways of managing the vulnerability of the clinical encounter. Fewer men in the current study received clinical care compared to women, pointing to gendered inequities in service provision that have been documented elsewhere (Gahagan et al., 2007; Marcell & Ellen, 2012; Shoveller et al., 2010). However, when young men in the current study did present for care, they described gender-specific needs. Young men tended to manage the vulnerability of the encounter by “getting in and getting out” of the exam room as quickly as possible, preferring speed and efficiency, and minimizing their exposure to a potentially difficult situation. Women, on the other hand, tended to seek warmth and a higher level of reciprocity in a more personal style of interaction with clinicians in order to decrease the vulnerability they experienced.

The findings related to gender-specific needs provide valuable insights for integrating the construct of gender in the provision of care that have not been reported elsewhere. This is likely because few other researchers have concentrated on the power relation and processes of the clinical encounter as viewed from young people’s perspective. The difference between clinicians’ and young people’s gendered perspectives revealed yet another discrepancy between young people’s wants and needs and the clinical encounter they were offered. Approaches to care that did not integrate the construct of gender in a substantive manner could not attend to gender specific needs.
Shifting the Clinical Agenda

In summary, young people’s perspectives have highlighted their need to discuss sexuality with the understanding that acceptance and support are required in navigating both the dangers and pleasures of sexual activity. In addition, young people’s perspectives indicate a need to consider the influence of intersections of social positioning—of which age, gender, and sexuality are just a few examples—in clinical encounters promoting sexual health. To provide effective sexual health services, the clinical agenda needs to shift and be brought more into line with young people’s needs and expectations. Furthermore, based on the human-rights framework in which this analysis is situated, it is easy to argue that young people should be provided with services that are relevant to their needs (Flicker et al., 2009; Gahagan et al., 2007). In fact, the WHO endorsed “the possibility of having pleasurable and safe sexual experiences” as well as “the right to pursue a satisfying, safe and pleasurable sexual life” (2006) in their definitions of sexual rights and sexual health. In the Canadian context, guidelines for sexual health (2008) indicate the need for clinical care that is skill building, comprehensive, and accessible to the target population, further reinforcing the need to listen and attend to young people’s perceived needs. Moreover, the need to consult with young people regarding all matters that affect them, including sexual health, is upheld by the provisions and the principles of the UN Convention on the Rights of the Child (1989).

However, even from the point of view of pragmatism alone, it can be argued that clinical care would be more effective, with improved sexual health outcomes, if it incorporated discussions that normalize youth sexuality, sexual pleasure, and healthy sexual development and are less focused on agendas of regulation and control. Without doubt, young people engage more readily with respectful clinicians who have a better understanding of their perspectives. In
addition, recent studies show how sexual health outcomes have been improved when clinical content incorporates the “critical co-constitutive relationship between pleasure and empowerment and between empowerment and sexual decision-making” (Oliver et al., 2013, p. 146). A study from the Institute of Development Studies in Brighton, United Kingdom, demonstrated that, with respect to HIV and STI prevention, public health outcomes would improve with the addition of discussions about positive sexual experiences (Institute of Development Studies, 2005). Other studies have also demonstrated that failing to incorporate sexual pleasure has a negative influence on people’s abilities to negotiate safer sex (Ingham, 2005). These findings indicate that incorporating pleasure should be a routine aspect of effective practice. The current study adds to the growing evidence that it is essential to integrate sexual pleasure not only into the sexual education done in schools, but also in the clinical care of young people.

In discussions of best practices there is no longer any debate that both young men’s and young women’s perspectives, emerging through intersections of social positioning, need to be taken into account in planning effective sexual health services, especially given the embedded nature of the gendered social contexts within which sexuality is understood, constructed, and regulated (Gahagan et al., 2007; Tolman et al., 2003). In addition to including sex-positive approaches, the inclusion of constructs of gender seems especially relevant to effective service planning in an environment where young men’s sexual health needs have been deemphasized and often ignored (Saewyc, 2012).

What actually stands in the way of a sex-positive clinical practice that is responsive to the complex web of influences that contextualize sexuality? Researchers, educators, and advocates for young people have been calling for the inclusion of sexual pleasure and gender as key
constructs in sexual health education, and sometimes even in clinical service provision, for many years. In 1988, Michelle Fine wrote her foundational work describing the need to include pleasure and desire in the sexual health education of young girls and women. In the 25 years that have passed, educators, theorists, feminist scholars, and youth advocates have continued to present serious challenges to sex-negative constructions of young people’s sexuality, especially for young women, emphasizing the relationship between sexual risk and the absence of pleasure and desire in sexual health education (Bay-Cheng & Lewis, 2006; Fine & McClelland, 2006).

These authors have emphasized the ways in which sex-negative practice has hampered young people’s abilities to develop and express a strong sense of their sexual subjectivity—their preferences, their rights and responsibilities, and their sexual limits. Since the mid ‘90s, international and national conferences on sexual health have highlighted gender equity and shared power relations between men and women (Gahagan et al., 2007). However, now, more than two decades later, there is still little tangible evidence, including the results from this study, suggesting that pleasure, desire, or gender have been well integrated into clinical service provision.

**Dimensions of social context as obstacles to change**

Despite a large number of studies on the efficacy of various clinical interventions, there has been much less focus on the ideologies embedded in relations of power that construct “normal” adolescent sexuality, and in turn on the context of those ideologies under scrutiny here—the clinical encounters aimed at promoting sexual health. As part of my research approach, I have considered how “such constructs may be reified” (Bay-Cheng & Lewis, 2006, p. 71), often to young people’s detriment. This critical approach within a particular Canadian locale identified how social context, where hegemonic ideologies and social beliefs about young
people are manifest, not only contributed to discrepancies between young people’s perceived needs and the clinical encounters they actually received, but also created potential resistance to change. The analysis of clinical encounters and the way young people and their sexualities were constructed in the current study have not only illustrated the particularities of clinical practice in Victoria, British Columbia, but also serve as reflections about dominant ideologies about young people, sexuality, and gender operating in a broader social context.

In the next section of this chapter, I explore several reasons for the persistent investment in the approach to clinical practice that is focused on risks and dangers, an investment that stands in the way of responding to the sexual health service needs that young people presented in the study. These reasons include ideologies, structural barriers, and the influence of space and place.

**Ideas as obstacles.**

In this study a dominant ideology of youth sex as risky has been linked to a persistent focus on the negative outcomes of sexual activity. This hegemonic ideology involves the social constitution of young people’s sexuality as problematic or dangerous, justifying clinical agendas focused on risk management and leaving little room to attend to sexuality or the practices of sex. This makes sense if the primary goal of clinical engagement is regulation and control to limit the consequences of sexual behaviour, but not if healthy sex itself is part of the desired outcome (Fortenberry, 2014).

Linked to this hegemonic ideology are further social constructions of young people as a group. Since 1904, when it was “discovered” (Hall, 1905), adolescence has been constructed as a period of emotional disturbance, linked to biologically determined changes and behavioural correlates. In this dominant and negative way of thinking about young people, individuals undergoing the biological changes associated with maturation are believed have a lesser capacity
for rational thought and decision-making about sex compared to older people. In this study, consistent with this accepted, yet problematic, way of thinking, young people’s perspectives on sexual matters were not always seen as equal to those of the (adult) clinicians.

Also underlying the hegemonic ideology of youth sex as risky are further assumptions about a drive model of sexuality (Bay-Cheng, 2003). According to this model, as discussed in Chapter 2, sexual behaviour is produced by uncontrollable and biologically based sexual urges, “raging hormones” that operate in concert with underdeveloped judgment. Such hormonal determinism can produce negative expectations and concerns that young people as a group, independent of their social context, are hypersexual, as well as pre-disposed to making poor choices (Bay-Cheng), perhaps “irresponsible” or “ignorant.” Such negative expectations and concerns were consistent with clinicians’ focus on the containment and control of sexual behaviour in the form of health education directed towards risk management. In keeping with worries about containment and control of irrepressible sexual urges, sexual pleasure or the emotions related to sexuality were rarely discussed, even though they were a significant part of young people’s perspectives and feelings about sexuality.

Neoliberal ideologies of self-determination, free choice, and personal responsibility can also be linked to the hegemonic ideology of youth sex as risky. Managing the problems of sex among young people deemed as risky involved directing attention towards individual people and their individual knowledge, as opposed to fulfilling goals directed toward broader social contexts that could create enabling environments for sexual health. Robertson identifies that this focus on the individual is part of a wider movement in social policy to direct responsibility for health towards the individual (2007).
**Policies and practices as obstacles.**

Policies and practices that clinicians in this study identified at an organizational level were sometimes named as obstacles to responding to the needs of young people. Clinicians described how clinic policies, underpinned by different funding models, including fee for service practice, created time pressures they perceived as barriers to meaningful discussion or comprehensive and good quality client care. Practitioners described time pressures as limiting the range of topics that could be discussed, as well as limiting clinician’s abilities to respond to individual needs. These reports from practices in Victoria may be considered typical; in Canada, community sexual health services continue to be underfunded, and practitioners provide the most they can with meager resources (van der Meulen, Oliver, Flicker, & Travers, 2010). Under these conditions of financial scarcity, clinic policies and procedures have often been shaped by significant and pressing administrative concerns related to scarce resources, leading to efficient delivery of services sometimes being valued over their effectiveness.

In a social context where funding devoted to health services for young people is usually inadequate, valuing efficiency over effectiveness makes it difficult, if not impossible, to bring care in line with young people’s needs. Young people in this study asked that opportunities be created for meaningful discussion. Most young people, with the exception of some young men who wanted “to get in and get out,” wanted time to talk with clinicians. Opportunities for meaningful conversation are difficult to provide when efficiency is the prime measure of quality service provision.

**Space and place as obstacles.**

While the clinical locales in this study varied, some key features of space and place, as dimensions of social context, were visible across the research sites. Young people’s positioning
as either invisible within the category of adult or as marginalized “add-ons” in the provision of sexual health care was both made manifest in and a consequence of the milieu where care was delivered—on the margins of town and on the margins of respectability, in the poorer areas of the city. It could be argued that even the alternative clinic settings included in the study, created especially for young people, embodied power relations that simultaneously honored them, while also constructing and maintaining their lower position within the material order. Specific structural and organizational processes in the clinical settings emphasized social differences between clients and clinicians and also served as concrete reminders of regulatory clinical agendas. Since the delivery of care cannot be separated from the physical setting, this “emplacement of power relations” (Poland et al., 2005, p. 17) is yet another dimension of social context in medical settings that shapes the perspectives that clinicians and young people bring to the clinical encounter—keeping “them” in their place.

The previous analysis suggests that complex relations of power maintain ideologies as well as policies and practices at both material and discursive levels and affect clinical practice in particular ways. In addition, the clinical encounter is an activity governed by space and place as a key dimension of social context. Therefore, the mechanisms from which arise the danger and disease approaches to sexual health practice will not be removed or changed simply by naming them. However, recognizing how these complex webs of social and power relations are relevant will remain an ongoing challenge for those interested in the design and delivery of sex-positive clinical practice.

**Implications for Nurse Researchers**

Integrating intersectional theory enables researchers to conceptualize research problems differently. By identifying “important intersecting social locations and systems” (Hankivsky et
al., 2012, p. 8) of inequality in the realm of health care, for example, researchers can address the dynamics of power and its effects. In this study intersectional thinking strengthened the way the research problem was framed because it led the researcher to see the importance of social location and power relations in the social context that shapes clinical encounters for sexual health. However, applying an intersectional approach was a challenge since the translation of theory into method is complex; even “self-identified intersectionality scholars” (Hankivsky et al., 2010, p. 3) struggle to elucidate methods that operationalize a variety of intersecting and multiple differences. Intersectional approaches remain underutilized in nursing research because theoretically informed yet practical methods and tools are lacking (Dhamoon & Hankivsky, 2011). Therefore, in this early stage of methodological development, this study provides an example of how a research problem might be framed as well as its practical application. It thus contributes toward the important work of forging a stronger connection between theory and practice, both in nursing and in intersectionality, “providing one more set of tools available to deconstruct the work of power” (Dhamoon & Hankivsky, 2011, p. 17).

The two-stage analysis used in this study, similar to that described by Sirma Bilge (2009), beginning with an inductive stage focused on identifying emerging themes, followed by a second deductive stage in which the researcher forged connections between individual perspectives, social locations, and broader social and structural contexts, may inform other qualitative approaches in health research. This process of analysis offered advantages in harnessing the strengths of qualitative descriptive analysis and critical ethnographic approaches. Using intersectionality to inspire that analysis also helped to conceptualize the influence of social locations separately, and also promoted an interactive analysis that connected these social locations and broader social relations.
The study design, which took into account both young people’s and clinicians’ perspectives, also offered additional strengths. Considering both perspectives acknowledged and highlighted the complex process of the clinical encounter. As I reflected on the study results I became more aware that not only were the voices of young people not included in the research about sexual health, but clinicians’ perspectives were also in some ways were not being fully considered. Though clinicians may be marked as privileged, their view of themselves in the clinical relationship were neither known nor understood by others, highlighting, once again, how circumstances are rarely marked solely by either privilege or oppression. Research designs that similarly aim to contrast and consider both professional and lay accounts in other areas of health research may prove similarly useful in terms of offering new insights for practice (e.g. Robertson, 2007).

Finally, a potential contribution of this study is to illustrate how ethnographic research methods can take into account how place and space matter in a way that informs practice, while opening “it up to critical scrutiny” (Poland et al., 2005, p. 178). These research methods attend to how power relations become manifest in time and space, embedded in specific clinical settings.

Suggestions for Clinicians and the Wider Community

The findings described here have important practical and theoretical implications for sexual health practice and the broader health care community. Since the ultimate goal of work inspired by intersectionality is to advance social justice issues (Hankivsky & Cormier, 2009), suggestions for concrete action are central to critiques of power in the clinical encounter. The suggestions for action correspond with key areas of discrepancy between young people’s self-described needs and the clinical encounters they received.
Implementing a sex-positive approach for clinicians

*Healthy sexual development.*

Promoting positive sexual health instead of only managing risks requires a shift in clinical thinking. Of course, this does not mean that negative sexual health outcomes should not be discussed. Instead, the purpose of the clinical encounter should shift toward including healthy sexual decisions and healthy sexual development.

*Posing questions.* When appropriate, sexual pleasure may be used as a point of origin for discussing a full range of sexual health issues, including contraception and STIs (van der Mulen et al., 2010). As part of such an approach, it can be useful to pose questions to promote discussion around young people’s preferred learning areas, such as healthy relationships and sexual pleasure. To this end, clinicians can develop and use their own set of sex-positive questions to ensure that the sexual health counselling that young people want and expect from clinical providers becomes a more routine part of clinical encounters.

*Developing new clinical content.* In terms of overall clinical program design, new clinical content will need to be further developed for a more comprehensive approach to sexual health. The International Planned Parenthood Framework for Comprehensive Sexuality Education advocates a “rights-based approach to equipping young people with the knowledge, skills, attitudes, and values they need to determine and enjoy their sexualities—physically, emotionally, individually and in relationships” (Braken, Shand, de Silva, & IPPF Adolescent team, 2010, p. 5). Knowledge and skills “focused on sexual function and relationship capacity building” (Fortenberry, 2014, p. 80), and values and guidance emphasizing self-determination of sexuality could promote healthy sex and sexual agency for young people (Schalet, 2004). Addressing
healthy sex as a goal of the clinical encounter would require an individualized approach that attends to diversity in experience and the ways this diversity influences learning.

*Further education.* Education and skills training to augment clinicians’ knowledge and skills in working with young people would increase clinicians’ comfort in providing more sex-positive sexual health services. Changes to nursing and medical school curricula and training would also help to remedy some of the barriers that clinicians identify with respect to addressing sexual health issues: discomfort with topics related to sexuality, inadequate knowledge base, and worries that sexual health counselling is beyond their scope of practice (van der Meulen, Oliver, Flicker, & Travers, 2010).

*Providing acceptance.*

Findings from this study and many others demonstrate that young people’s expectations about being judged can serve as a barrier to obtaining services and to effective clinical interactions. Therefore, I outline some key ways that health care providers can try to provide an environment of acceptance.

*Cultivating self-awareness.* Clinicians who cultivate self-awareness begin to realize what they bring to the clinical interaction—their own stories about sexuality and their own culture, triggers and vulnerabilities. During the clinical encounter, it is important to avoid acting as the expert and losing the possibility of collaboration. An expert approach to the encounter can be triggered by not having enough time, or by the perceived need to cover *all* sexual health information. Information alone does not bring change. If clinicians avoid this trap they may be more responsive and therefore can focus on what young people want and need.

*Being openminded.* Clinicians who are open to being changed in the process of working with young people also have the ability to question “received knowledge” about sexual health—
about what they “hold to be self evident and true” (Poland et al., 2005, p. 61)—and remain curious about other perspectives.

*Awareness of power dynamics.* If clinicians think about their social location and where they fit in terms of class and gender relations and how this might influence their practice, they can bring a mindful and responsive approach to the encounter.

*Respecting choices.* Giving up the expert position also means trying not to “fix” problems and trying not to be helpful to the point that young people are inadvertently disempowered (Arthur et al., 2013). It is also helpful to use statements that make choice, respect, and collaboration explicit. For example, “What is most important for you that we should start with?” or “This may or may not work for you. You know yourself best.”

*Decreasing feelings of vulnerability.*

In this study and others, young people have described the clinical encounter as a moment of great vulnerability. This vulnerability may serve as a barrier in accessing care, so finding ways to decrease feelings of vulnerability is important.

*Recognizing agency.* Respectful and non-judgmental approaches that recognize young people “as owners of their own bodies” and as “agents of their own sexual behaviour” (Schalet, 2004, p. 38) can decrease feelings of vulnerability in the exam room. Another way to support young people could include providing them with the option of choosing the gender of the clinician (Soon et al., 2009). In addition, the young person must have an opportunity to meet the clinician and discuss their concerns before a physical examination. Bringing a friend or partner into the exam room can also work to increase comfort.

*Conveying permission, recognizing comfort levels, and providing time.* Other measures to decrease vulnerability include a) providing conversational openings as well as physical cues in
the clinic environment that signal “permission” to discuss sexual health; b) being sensitive to non-verbal and verbal cues that signal areas of concerns or topics that are “off-limits” in terms of the young person’s comfort; and c) allowing enough time to encourage discussion and personal attention to individual needs.

Creating welcoming settings. Choices about the clinical setting should involve consultations with key stakeholders, especially young clients, so that their ideas can be integrated. When possible, clinical settings should be located in central and safe areas of town. Keeping clinic areas clean, well maintained, and comfortable conveys the message that both the clients and their sexual health care are valued, a message that should then also emerge in clinical practices. Create environments that encourage interactions and conversations among young people and between young people and health and social care providers. For example, a kitchen area with a table and chairs and food served in the waiting area can promote interaction. A wall with “chalkboard paint” invites additional visual interest and an interactional focus. Work stations and sufficient plug-ins around the waiting room provide comfort and offer ways to relieve long wait times. Chairs in exam rooms can be arranged to invite conversation. Waiting areas and exam rooms should also offer sufficient privacy. For example, the waiting room should not be visible from the street or to others accessing the same building. Exam rooms could be sound-proofed so that privacy is maintained.

To help connect the environment to young people of all genders, materials should be focused towards a 15- to 24-year age range. Young people often work and attend school, so they will appreciate accessible opening hours. Hiring younger service providers and volunteers also creates and maintains youth connection. Posters, art, reading material, plants and natural light all help to create a welcoming, inclusive environment. Wall decorations such as art work, posters or
stickers can be specific to First Nations, young men, and LGBTQ young people. A variety of furniture styles, colours, and textures can help make the space feel less institutional and more welcoming for all.

Carefully consider compromises so that both valuable care and security measures can be implemented. When possible, eliminate sliding glass doors and high counters separating clients from reception or clinical staff. An open concept arrangement of the waiting and reception areas promotes easy interaction between staff and clients while also providing some quiet and private space for charting and conferencing.

*Gender-specific needs.*

Gender-specific needs should also be accommodated in the clinical encounter. An important aspect of this recommendation is that when clinicians plan care, they should take into account men’s and women’s gender-specific strategies for managing vulnerability.

*Acknowledging men’s needs.*

When working with young men, lean towards a friendly but “efficient” approach, especially in the early stages of the clinical relationship. This might mean asking a question or two to signal that you are open to conversation, but as always, remain respectful and responsive to their boundaries, following verbal and non-verbal cues. Be ready to act as resource broker, making appropriate referrals to help with needs that young men may not consider part of health service provision, such as counselling services. In addition, when young men enter the clinic, its physical environment should acknowledge their presence in the same way that it welcomes people of other genders, with visual and written material that refers to all genders in some way.

*Acknowledging women’s needs.*
When working with young women, clinicians should recognize that they often want clinicians to know them as individuals, and they want to know the clinicians as well (McKee et al., 2004). Often young women are seeking a personalized model of care that includes emotional engagement and reciprocity and that recognizes that sexual health needs can be linked closely to emotional needs. This type of patient-centered focus requires continuity of care.

A community-wide approach.

Promoting positive approaches to sexual health can never be the work of clinicians alone. Ideally, policy makers, program planners, community service providers, and health professionals would take part in building a comprehensive community education and service strategy that would create multiple and linked access points for young people to engage in discussions about sexual health. Van der Muelen et al. described the value of such connections: “The places for educating young people on sexual pleasure should not be limited to one type of service or another, but rather should exist in each service or program that youth might engage with when seeking sexual health information” (van der Meulen, Oliver, Flicker, & Travers, 2010, p. 146).

Finally, as clinicians in this study observed, one of the most fundamental requirements for meeting young people’s self-identified needs is adequate and sustained funding for sexual health services, thereby ensuring adequate time to spend talking with young people. As Masaro et al. (2012) and Oliver et al. (2010) explained, it is essential to look beyond the work of individual clinicians, towards broader health care structures within which services are provided. Structural limitations in the larger health care system have been identified as key barriers that shape and constrain effective practice. Going beyond risk management approaches means having sufficient resources to improve clinical care.
**Strengths and Limitations**

Although the study findings offer insights into the discrepancies between young people’s perceived wants and needs and the clinical encounters they actually receive, the findings do have some limitations. The need for confidentiality and privacy in clinical encounters for sexual health restricted the use of unstructured observation, an ethnographic data collection method sometimes used in qualitative descriptive studies (Sandelowski, 2000), thus limiting understandings about the social processes under study. In addition, my status as a clinician at one of the sites limited my observational abilities.

An intersectional perspective augmented the descriptive approach so that the analysis could inform knowledge about social location and power operating in the context of clinical encounters about sexual health. However, the analysis was limited in scope and did not consider multiple interactions across many aspects of social identity or compare different interactions relationally (Dhamoon & Hankivsky, 2011) to help account for variations “within and across social differences.” This study also did not include specific analyses of “processes of differentiation” such as racialization and gendering or “interactive systems of domination” such as heterosexism and homophobia (Dhamoon & Hankivsky, 2011, p. 24). Analyses focused on processes and systems offer an advantage in shifting focus away from identity and the risk of essentializing young people and instead towards the “doing” of difference and explicating how social norms are produced (Dhamoon & Hankivsky, 2011) in a nexus of power relations. I acknowledge that I may have inadvertently added to a tendency to universalize young people’s or clinicians’ experiences. In particular, not all young people feel judged by clinicians and not all clinicians wield disciplinary power over others. Intersecting social locations might influence how individuals construct themselves in the encounter, but these influences do not necessarily reflect
how individuals understand themselves. One project is always inadequate in addressing so many complexities of difference.

Furthermore, the study design is vulnerable to selection biases, and the study sample is confined to one small urban centre. However, while the study findings are not transferable to all clinicians, or to all young people, they expose issues that need to be addressed so that clinical services can be delivered that are relevant to the wants and needs of young people. Since young people’s perspectives remain an understudied aspect of sexual health care, attending to these perspectives is essential in developing new approaches to clinical encounters aimed to promote sexual health.

**Recommendations for Further Research**

Young people are not only the primary stakeholders in sexual health research and clinical service provision, but they are also the key resources for researchers who are concerned for making sexual health research and clinical service provision relevant to the needs of young people. Further research would continue to develop more comprehensive clinical content in consultation with both young people and clinicians. This new clinical content would be sex-positive, but also informed by intersectionality, because clinical encounters are shaped not only by gender, but also by other factors such as age, class and geography, which intersect in specific ways. These new approaches would need to be evaluated in terms of their efficacy in improving young people’s ability to negotiate safer sex and sexual health outcomes, and in terms of their relevance to young people’s wants and needs. Also, research should focus on identifying the education and training that clinicians would require to implement a sex-positive approach more in line with young people’s wants and needs. In addition, more research that demonstrates the relationship between pleasure and sexual agency, and between sexual agency and improved
sexual health outcomes, would further support the importance of adding information to clinical services about sexual pleasure. Finally, it is important to continue to build on knowledge about the social context of the clinical encounter that underpins clinicians’ and young people’s knowledge, attitudes, and practices.

Conclusions

In this and the preceding chapters, I have analyzed both young people’s and clinicians’ perspectives in clinical encounters in which the goal is to promote sexual health. The findings revealed significant discrepancies between young people’s perceived needs and the clinical encounters they actually received. I identified three key discrepancies between young people’s perceived needs to the clinical encounter they actually receive. First, instead of being limited to only negative conceptualizations of sexuality, young people valued sex-positive approaches to the clinical encounter. Second, instead of agendas of authority, young people preferred more equality in the clinical relationship, which they thought should be characterized by attitudes of non-judgment and respect for them as individuals. Third, instead of the gender-based understanding of risk described by clinicians, young people described gender-specific strategies for managing vulnerability in the clinical encounter.

As part of a critical approach, I have situated these discrepancies within a social context that shapes clinical encounters about sexual health. This critical descriptive approach identified how social context—hegemonic ideologies, structural barriers, and the influence of space and place in clinical settings—create resistance to shifting the clinical agenda to be more in line with young people’s needs and expectations.

The findings of the current study add to the growing evidence of the need to re-evaluate our approaches and develop new ones if sexual well-being is our aim. Young people’s sexuality
is inscribed and reinscribed in many different social contexts, including the clinical encounter. Therefore, the clinical encounter and the way clinicians make sense of themselves and their young clients informs the way we think about young people and their sexuality in the context of health. However, what happens in the exam room is only one piece of a complex reality. We live in a technological society saturated with sexualisation, the commodification of sexual agency, and ever evolving, confusing, and contradictory messages about sexuality. Clinicians need to accept that effective practice, salient to the everyday lives of young people, will always be a moving target.

To follow this moving target, I call on clinicians and clinical service planners to listen carefully to the voices of young people and to involve young people in participatory approaches to research and development of new clinical content. However, translating knowledge about what young people want into innovative responses in the clinical encounter is a challenging process. Dominant ideologies, structural relations, space and place, training, and personal experiences all play an important role in determining clinicians’ willingness to engage in sex-positive service provision. While acknowledging such complexities, we must continue to build on clinical knowledge as well as theoretical knowledge regarding underpinning ideologies that shape clinical interactions.

To carry out the clinical agenda that young people outlined here, a broad and passionate commitment to the health and well-being of young people will be the key requirement. The requirements of innovative clinical practice are but one piece of what is necessary. Governments, policy-makers, researchers, educators, clinicians, and public health authorities all have essential roles to play. Working within and across these groups to create the political will required to support new clinical agendas will be the most challenging task of all. Those who recognize the
essential role of sexual health within the comprehensive approach that is required to improve young people’s health will find this challenge difficult to resist.
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Appendices

A: Observation Guide

1) Note the use and organization of the clinic spaces and other physical elements in the environment.

2) What are the different steps that a client encounters in attending the clinic for sexual health visit?

3) What kinds of feelings emerge in response to the environment?

4) Observe any people in the setting, including dress, postures and movements. Observe their behaviours including verbal and non-verbal aspects of reality. What seems to be going on in the setting?
B: Youth Interview Guide

1) What has it been like for you to see a doctor or nurse for sexual health care? (or when you thought about seeing a doctor or nurse for sexual health care?) Walk me through the visit.

2) Was there a time when you visited the nurse/doctor and you didn’t get the help you were looking for? What might doctors/nurses need to know so that you could get the care you were looking for?

3) What do you need (will you need) when you make a visit for sexual health care? What do you want to happen in the visit? What makes it work for you? Describe the ideal visit.

4) Have you talked to your health care provider about anything else related to sex that didn’t have to do with birth control or sexually transmitted infections? What is it like (would it be like) if you could talk to the doctor or nurse about your own sexual experiences: your questions, worries, feelings and relationships, or about sexual pleasure instead of just ‘safe sex’ or birth control? What are they (doctors/nurses) missing? If you knew you could talk about anything you needed help with, what sexual topics would you want to discuss with a health care provider?

   Re sexual pleasure: How should health care providers ask about sexual pleasure? For example: Are you having trouble reaching orgasm? Do you have any questions about making sex better for you (and your partner)? Can you come up with some questions for doctors and nurses to ask young people?

5) As a girl/guy/trans youth what do you need to be comfortable when visiting a health care professional about your sexual health?
C: Clinician Interview Guide

1) What kinds of sexual health care do you provide for youth (ie. paps, contraception, abortion referrals, counselling)? Is this something you do a lot of or is this an infrequent event?

What are the easiest services to provide? What are the more challenging aspects? Why?

2) What do you consider to be meaningful elements of sexual health visits with youth?

3) What issues and concerns do you think that sexual health providers need to consider at these visits? Describe an ideal visit.

4) Do you think your approach to sexual health care for youth is different than other providers? How is it different? Why do you do it differently? What makes this different approach important to you? If it is not different, then what is contained in your standard approach?
D: Youth Focus Group Interview Guide

1) What is it like for people your age to visit a doctor or a nurse for sexual health care? Walk me through some visits you might have heard about (process).

2) Are there times when people your age don’t get the help they are looking for? What might doctors and nurses need to know so that youth get the help they need?

3) What are some of the things people your age need when they make a visit for sexual health care? What do you think people might want to happen in the visit? What might make the visit work for them? Describe the ideal visit.

4) Do you think that health care providers (nurses or doctors) should talk to people about more than preventing pregnancy and diseases? What would it be like (what is it like) if people your age could talk to the doctor or nurse about their own sexual experiences: their questions, worries, feelings and relationships, or about sexual pleasure instead of just ‘safe sex’ or birth control? What are they (doctors and nurses) missing? If people your age could talk about anything they needed help with, what sexual topics do you think they might want to discuss with a health care provider?

5) How should health care providers ask about sexual pleasure? For example: Are you having trouble reaching orgasm? Do you have any questions about making sex better for you (and your partner)? Can you come up with some questions for doctors and nurses to ask young people?

What do you think girls/guys/sexual minority youth need to be comfortable in visiting a health care professional about sexual health? How might being poor change things?
E: Clinician Focus Group Guide

Introduction

In your education how much attention was devoted to addressing sexual health concerns with youth? Knowing what you know now, what should be included in your educational experience?

1) Who should be providing sexual health care to youth? What kinds of services should be provided and in what settings? What is it like for clinicians to provide sexual health care to youth?

2) What do clinicians consider to be meaningful elements of sexual health visits with youth? Describe an ideal visit.

3) What do you think youth want and need at sexual health visits? Do you think anything is missing?

If appropriate…

4) In the conversations so far we have focused primarily on risk behaviours and health problems. Do clinicians ever focus on broader sexual health topics? Should they? Why? How should we ask youth about sexual pleasure? For example… Do you have any questions about how to make sex better for you (and your partner)?
Clinician focus group.

MAKING SPACE FOR YOUTH VOICES: ADOLESCENT AND CLINICIAN PERSPECTIVES ON CLINICAL ENCOUNTERS FOR SEXUAL HEALTH

Principal Investigator: Dr. Elizabeth Saewyc
[604-XXX-XXX]
[email address]

Research Coordinator and Contact for Study: Kim Daly
[250-XXX-XXX]
[email address]

STUDY INFORMATION AND CONSENT FORM

Study Purpose: You are being invited to discuss health care provider perspectives on clinical encounters for sexual health for youth. While health care providers and youth identify many of the same sexual health issues, they often differ in what they consider ideal approaches for resolution. For this reason it is important to hear health care providers perspectives and examine any discrepancy between youths’ perceived needs and the clinical encounters they actually receive.

Focus Groups: We are looking for health care providers to participate in focus groups. These sessions will be digitally recorded and then transcribed. If you agree and are eligible, we will arrange a time and place for you to participate in a focus group. Focus group interviews will be 60-90 minutes in length. One of our project members will ask the group (6-8 clinicians) to share their perspectives on clinical encounters for sexual health with young people, including what clinicians consider to be meaningful elements in these encounters. We will not ask you specifically about your personal experiences delivering clinical care promoting sexual health, but just about opinions and perspectives that other clinicians might also share.

For participating in this study, you will receive $20 as an honorarium to acknowledge your expertise and personal contribution to the study.

Refusal or withdrawal from the study will in no way affect your work or your participation in ongoing or future research studies.

Risks and Benefits of Study: You may not personally benefit from participating in this project, but your input will help improve this study so it can better inform sexual health services for youth on Vancouver Island. There are potential risks to participation; you may feel uncomfortable talking about perspectives on clinical encounters for sexual health. Participation in group sessions will mean that your name and statements will be known to the group, and in this sense some anonymity and privacy will be lost to other members of the group.

Confidentiality: We cannot guarantee others in the group won’t share information outside the session, but we will remind everyone to be respectful and keep anything they hear in the group confidential.
However, other steps taken to protect your privacy include ensuring no names or identifying information will be on any notes or tapes. CDs of digital files will be stored in a locked cabinet for 5 years and then destroyed. Interview notes and transcripts will also be stored in a locked cabinet and a password-locked computer for up to 10 years and then destroyed. Signed consent forms will be stored separately from notes, in a locked cabinet. To further protect your privacy, information from the notes and transcripts will be stored on password-protected computers, and only project staff will have access to this de-identified data. All reports presented from this project will only report information in ways that no one person can be identified.

If you have any questions about this study at any time, please contact Dr. Elizabeth Saewyc or Kim Daly at the phone numbers listed above.

If you have any concerns about your treatment or rights as a research subject, please contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

Thank you for your cooperation and interest in this study.

IF YOU AGREE TO PARTICIPATE, PLEASE CALL 250-XXX-XXXX TO SCHEDULE AN INTERVIEW SESSION OR FIND OUT WHEN THE NEXT FOCUS GROUP IS SCHEDULED.

Consent

I have had an opportunity to read this consent form and have received satisfactory answers to any questions that I have had. I understand my participation in this project is voluntary. I can refuse to participate or withdraw from the study at any time, without affecting any relationship I might have to UBC. By signing this form I confirm that I understand what is being asked of me, and by marking “Yes” am agreeing to participate in a focus group.

Yes____ No____ I agree to participate in a focus group.

Printed Name                      Signature                      Date
Physician interviews.

The University of British Columbia
Behavioural Research Ethics Board
Office of Research Services
Suite 102, 6190 Agronomy Road
Vancouver, B.C. V6T 1Z3
Phone: (604) 827-5112, Fax: (604) 822-5093

The University of British Columbia
School of Nursing
T201-2111 Wesbrook Mall
Vancouver, B.C. V6T 2B5
Phone: (604) 827-7417, Fax: (604) 822-7466

Making Space for Youth Voices: Adolescent and Clinician Perspectives
On Clinical Encounters for Sexual Health

Principal Investigator:
Dr. Elizabeth Saewyc
Associate Professor
University of British Columbia School of Nursing
604-XXX-XXXX

Co-Investigator:
Kim Daly
PhD candidate
University of British Columbia School Nursing
250-XXX-XXXX

This research is to fulfill the requirements of Kim Daly’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

Purpose

The purpose of this study is to examine what youth want and need in clinical encounters for sexual health. While health care providers and youth identify many of the same sexual health issues, they often differ in what they consider ideal approaches for resolution. For this reason it is important to hear health care providers perspectives and examine any discrepancy between youths’ perceived needs and the clinical encounters they actually receive. You have been invited to take part in this research because you are a physician who works in primary care with youth.
Study procedures

If you agree to participate in this study, a researcher will conduct an interview with you to discuss your perspectives on clinical encounters for sexual health with youth. The interview will be audio-recorded and will take approximately 30-90 minutes. It will occur at a time and place that is mutually agreeable to you and the researcher. In this confidential interview, the researcher will ask you questions about your experiences and perspectives on providing clinical encounters aimed to promote sexual health for young people. The researcher may ask to interview you a second time at a later date in order to clarify some of your previous responses.

Potential risks

Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher discuss your work and ask questions. These conversations with you will be held in strict confidence. There is also a remote possibility that you may experience some emotional discomfort when sharing difficult experiences from your work.

Potential benefits

Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of sexual health practice with young people. You may also experience some benefit from the opportunity to talk about your clinical experiences.

Confidentiality

The identity of all participants will be kept strictly confidential. However, since your work is involved with other healthcare workers, they may be aware of your participation in the study. All of the researcher’s observations, notes, and conversations with you will be kept confidential. All audio-taped interviews will be transcribed and all identifiers (such as names and places) will be removed from the transcribed data. Participants will be identified by pseudonyms. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection.

Contact for information about the study
If you have any questions or desire further information with respect to this study, you may contact Kim Daly at 250-XXX-XXXX or via email at XXX.

**Contact for concerns about the rights of research subjects**

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-XXX-XXXX or if long distance, e-mail to XXX.

**Consent**

Your participation in this study is entirely voluntary. You may refuse to participate or withdraw from the study at any time without jeopardy, and without affecting any relationship you might have with UBC. If you wish to withdraw from the study at any point, your data will be removed from the study.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

________________________________________________________________________________________

Subject Signature Date
Nurse interviews.

The University of British Columbia Behavioural Research Ethics Board
Office of Research Services
Suite 102, 6190 Agronomy Road
Vancouver, B.C. V6T 1Z3
Phone: (604) 827-5112, Fax: (604) 822-5093

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Making Space for Youth Voices: Adolescent and Clinician Perspectives

On Clinical Encounters for Sexual Health

Principal Investigator:
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Associate Professor
University of British Columbia School of Nursing
604-XXX-XXXX

Co-Investigator:
Kim Daly
PhD candidate
University of British Columbia School Nursing
250-XXX-XXXX

This research is to fulfill the requirements of Kim Daly’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

Purpose

The purpose of this study is to examine what youth want and need in clinical encounters for sexual health. While health care providers and youth identify many of the same sexual health issues, they often differ in what they consider ideal approaches for resolution. For this reason it is important to hear health care providers perspectives and examine any discrepancy between youths’ perceived needs and the clinical encounters they actually receive. You have been invited to take part in this research because you are a nurse who works in primary care with youth.
**Study procedures**

If you agree to participate in this study, a researcher will conduct an interview with you to discuss your perspectives on clinical encounters for sexual health with youth. The interview will be audio-recorded and will take between 30-90 minutes. It will occur at a time and place that is mutually agreeable to you and the researcher. In this confidential interview, the researcher will ask you questions about your experiences and perspectives on providing clinical encounters aimed to promote sexual health for young people. The researcher may ask to interview you a second time at a later date in order to clarify some of your previous responses.

**Potential risks**

Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher discuss your work and ask questions. These conversations with you will be held in strict confidence. There is also a remote possibility that you may experience some emotional discomfort when sharing difficult experiences from your work.

**Potential benefits**

Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of sexual health practice with young people. You may also experience some benefit from the opportunity to talk about your nursing experiences.

**Confidentiality**

The identity of all participants will be kept strictly confidential. However, since your work is involved with other healthcare workers, they may be aware of your participation in the study. All of the researcher’s observations, notes, and conversations with you will be kept confidential. All audio-taped interviews will be transcribed and all identifiers (such as names and places) will be removed from the transcribed data. Participants will be identified by pseudonyms. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection.

**Contact for information about the study**
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**Contact for concerns about the rights of research subjects**

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**Consent**

Your participation in this study is entirely voluntary. You may refuse to participate or withdraw from the study at any time, without jeopardy to your employment and without affecting any relationship you might have with UBC. If you wish to withdraw from the study at any point, your data will be removed from the study.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

____________________________________________________
Participant Signature                        Date
Youth focus groups and interviews.

MAKING SPACE FOR YOUTH VOICES: ADOLESCENT AND CLINICIAN PERSPECTIVES ON CLINICAL ENCOUNTERS FOR SEXUAL HEALTH

Principal Investigator: Dr. Elizabeth Saewyc
[604-XXX-XXXX]
[email address]

Research Coordinator and Contact for Study: Kim Daly
[250-XXX-XXXX]
[email address]

STUDY INFORMATION AND CONSENT FORM

Study Purpose: You are being invited to be part of a study that will assess young people’s sexual health needs when visiting a nurse or a doctor. This will help plan health services to better meet the needs of youth.

Methods: We are looking for youth ages 16 to 19 yrs to participate in an individual interview or a focus group, or both. These sessions will be digitally recorded and then transcribed. If you agree and are eligible, we will arrange a time and place for you to be interviewed and/or to participate in a focus group.

1. Focus group interviews (approx. 1 hr): One of our project members will first ask the group (6-8 youth) to complete a survey of questions about some of the main issues or concerns for young people that doctors and nurses need to know more about. Then the group will talk about some things people your age might need when they make a visit for sexual health care and about things that may be missing from the sexual health care. We will not ask you specifically about personal experiences with sexual health or sexual health care, but just about your opinions and what you think other people your age might want.

2. Individual interviews (approx. 1.5 to 2 hours): One of our project members will interview you about what you want and need when visiting the doctor or nurse for sexual health. You will have the opportunity to tell researchers about your main issues or concerns that doctors or nurses need to know more about.

For participating in this study, you will receive $20 to thank you for your time. If you need transportation to attend the focus group or interview, you will be reimbursed with bus tickets.

Refusal or withdrawal from the study will in no way affect any treatment, clinical care, or support that you are currently receiving or your participation in ongoing or future research studies.

Risks and Benefits of Study: You may not personally benefit from participating in this project, but your input will help improve sexual health services for youth on Vancouver Island. There are potential risks to participation; you may feel uncomfortable talking about experiences with sexual health care visits. You can refuse to answer any questions you don’t want to. In the focus group, if you share your experiences around sexual health care, other people in the group might talk about what you said outside the focus group. We will tell participants before beginning and at the end to keep what is said private.

Confidentiality: We cannot guarantee others in the group won’t share information outside the session, but we will remind everyone to be respectful and keep anything they hear in the group confidential. Other
steps we take to protect your privacy include ensuring no names or identifying information will be on any
notes or tapes or surveys. The questionnaires and CDs of digital files will be stored in a locked cabinet for
5 years and then destroyed. Interview notes and transcripts will also be stored in a locked cabinet and a
password-locked computer for up to 10 years and then destroyed. Signed consent forms will be stored
separately from notes, in a locked cabinet. To further protect your privacy, information from the notes and
transcripts will be stored on password-protected computers, and only project staff will have access to this
de-identified data. All reports presented from this project will only report information in ways that no one
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Thank you for your cooperation and interest in this study.

IF YOU AGREE TO PARTICIPATE, PLEASE CALL 250-XXX-XXXX TO SCHEDULE AN
INTERVIEW SESSION OR FIND OUT WHEN THE NEXT FOCUS GROUP IS SCHEDULED.

------------------------------------cut here to return (keep the rest as your copy)-------------------------------

Youth Consent

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questions that I have had. I understand my participation in this project is voluntary. I can refuse to
participate or withdraw from the study at any time, without affecting any relationship I might have with
UBC. By signing this form I confirm that I understand what is being asked of me, and by marking “Yes” am
agreeing to participate in an individual interview or focus group or both.

Yes___ No___ I agree to participate in an individual interview.

Yes___ No___ I agree to participate in a focus group.

____________________________________________
Printed Name                        Signature                        Date