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Counseling Adolescents About Long-Acting Reversible Contraception

Dr. Ramnarine:
Welcome to *Advances in Women's Health* on ReachMD. I'm Dr. Shelina Ramnarine, and joining me to share best practices for counseling adolescents with long-acting reversible contraception is Dr. Maureen Baldwin. She's an Associate Professor of Obstetrics and Gynecology at the Oregon Health and Science University Center for Women's Health in Portland. Dr. Baldwin, thanks so much for being here today.

Dr. Baldwin:
Thank you for having me. I'm excited to talk about this topic.

Dr. Ramnarine:
To begin, Dr. Baldwin, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics both recommend intrauterine devices and contraceptive implants as first-line options for adolescents. Could you tell us a bit about what's driving that recommendation? What does the evidence tell us about safety and effectiveness of these methods, as well as how satisfied adolescents tend to be with them?

Dr. Baldwin:
Yeah, we're talking about IUDs, and contraceptive implants. They're considered in the family of long-acting reversible contraceptives, which we call LARC methods. So the LARC methods, once they're placed, they don't require any maintenance, so you don't have to remember to do anything about them. And so generally, they have a little bit higher effectiveness for birth control compared to the shorter-acting methods that do require remembering and getting a prescription renewal and picking it up at the pharmacy and then not forgetting to take it that day, etc.

So when there's something that doesn't require remembering, the failure rate's a lot lower. So we actually know that that's even better for teenagers than for adults, because teenagers might be a little bit more susceptible to needing to remember stuff. Although, in my experience, they're pretty good, to be honest.

When we use a LARC method really well compared to when we use a short-acting method really well, it actually is up to 25 times more effective for birth control, which is a huge number. And so, once we found that data out, a lot of agencies were like, "Hey, we should really promote these LARC methods as the main method for teens." But at the same time, we were coming up on—and this is around 2009, 2014-ish—the concept of really understanding that the method that the patient likes is actually going to be much more effective than the method the patient is annoyed with, because patient preference plays a huge role in how long they use the method, how much they continue it, use it from month to month, and don't ask to have it removed, for example.

So a teenager using an IUD might feel a little bit pressured to have a pelvic exam when they don't quite feel ready for it, and we don't want to promote that they should start with an IUD just because it's so much more effective. We should promote that they start with a method that feels most comfortable to them and has a side effect profile that agrees with them.

Dr. Ramnarine:
Now, despite those recommendations, many clinicians still encounter concerns that long-acting reversible contraceptive methods may affect future fertility, increase infection risk, or simply aren't appropriate for teenagers. In your experience, which misconceptions are most common, and how do you address them during counseling conversations?

Dr. Baldwin:
I think these misconceptions are still a little bit out there, and a lot of times they have to do with the patient's parents' experience. So if the parent—particularly the mom or the stepmom—had a bad experience with an IUD in the past, they might really influence the way that the teen is feeling about using that medication.

There are a lot of concerns about infertility in particular, and I think there's a lot of social media driving that concern. But there is no concern about infertility after using any kind of contraceptive. Whether it's a pill or a vaginal ring or the implant or the IUD, there's really no complication that I can think of that would influence fertility other than having a major infection, which is extremely rare and not related to having any of these medications.

Dr. Ramnarine:
Another barrier we hear about is fear of pain—whether that's anxiety about the insertion itself or concerns about side effects afterwards. With that being said, what should adolescents realistically expect, and what strategies can help make the experience more comfortable?

Dr. Baldwin:
It's definitely a concern that it might be an uncomfortable procedure. And that's enough of a reason for people not to feel ready for using it. And I think starting off with a position of trust with your patient is the most important thing. So I'm always going to tell people about the options that we have for managing pain, and then, if they're not feeling ready for it, I'm not going push it.

So with the implant, it's about a 30-second procedure, and the most uncomfortable part of the procedure is placing an anesthetic injection. And I ask my patients to count how long it takes it to get numb once I put the injection in, and we're up to about nine seconds. So you got nine seconds of a pinchy injection—a lot of people can't handle that, and I understand that—but it's not too bad. And then the actual placement is not painful if the injection's put in the right location. So the implant's actually pretty tolerable for people who can handle the concept of a needle. The IUD is a pelvic exam, which is, by itself, uncomfortable, and if you haven't ever had one before, there's an anxiety component upon that.

And then, also, there's a real wide variety in how uncomfortable the actual placement is from one person to another. And there's a lot of different adjunct medications and methods we can use to help with that discomfort, which, of course, is a range from person to person. At our clinic, we offer a huge range, including having a pediatric anesthesia doctor come to the clinic and having them be asleep for the procedure, all the way to using a syrup that you drink to feel really relaxed, to having an injection around the cervix to help with numbing.

And we're promoting a lot of these methods for clinics that place IUDs, especially for teenagers—but for adults, too—to be able to improve the experience. If a teen is having a first pelvic exam and an IUD at the same time, my goal is to make it the best possible experience. I would offer a pedicure at the same time if I could, because you just want that first gynecology experience to be setting the tone for their whole entire gynecology future.

Dr. Ramnarine:
For those just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Shelina Ramnarine, and I'm speaking with Dr. Maureen Baldwin about effective approaches to counseling adolescents about long-acting reversible contraceptive methods.

So, Dr. Baldwin, we know that adolescents often arrive in the office with varying levels of knowledge and comfort around reproductive health decisions. From your perspective, what does developmentally appropriate, patient-centered contraceptive counseling look like in practice, and how can clinicians build trust from the start?

Dr. Baldwin:
Contraceptive counseling can look different, especially for a teen, from one person to another. So it might be an appointment where a teen comes in alone and says, "Hey, I would like birth control because I'm going to start having sex." And so we'd be talking about healthy sexual relationships. We'd be talking about their preferences for what their period looks like on different medications, whether they are looking for a hormonal medication or not, and what are other preferences are important to them. And we'd also be reviewing what methods are safe for them based on their medical history. For a teenager, we'll typically offer and maybe sometimes even recommend a follow-up visit, just to make sure that the method that we discussed is working for them and that they know how to access it and use it.

I'll also be asking them if they want me to have their parent involved in the discussion, because sometimes parents can help reinforce the remembering part of things and help facilitate the prescription pickup and stuff like that. Other times, a parent might bring a child in and say that they want to talk about birth control, but then when I probe, it's really that they want to talk about period management, and they're not anticipating being sexually active anytime soon.

It's also really important to keep in mind that not every teen has the same background knowledge about birth control options, what's

normal or not with a period, or even about their sexual health or sexual relationships. And so I like to ask a lot of open-ended questions and say, "What do you understand about this? And what do you know? And what do your friends know?" And that includes teaching the parents, too. So if parents come in, I always offer that I'm going to talk to the teen privately for at least a portion of the visit. But a lot of times, it can be really helpful to emphasize some of the main aspects with the parent present—such as the safety of the medication and the importance of daily use— and also just normalize that sexual behaviors are normal in people, including in teenagers, to make sure that the parent understands that the teen is being responsible.

Dr. Ramnarine:
Now, parents and caregivers may also have their own concerns or expectations that differ from the adolescents. So how do you navigate those discussions while maintaining a focus on the patient's needs, preferences, and confidentiality?

Dr. Baldwin:
Yeah, this is a tricky subject. I try to get the vibe of how the parent's feeling about things. I ask the parent specific, open-ended questions also, like, "What are you hoping to achieve today, and what are your goals for this experience?" But I also make sure the teen knows that they're actually the locus of control for the visit and that they are the ultimate decision-maker.

And it's very clear many times that the parent has an agenda or that the teen's choices are not exactly what the parent agrees with. And so I do try to help navigate that. I'm a parent also, and I understand that sometimes a parent does know what their child has experience with previously, and so I recognize the importance of the parent's involvement in the discussion. But it's also a good opportunity to teach a teen how to navigate working with a healthcare provider, and I also want that experience to go well, too. So I want them to know that they can ask questions and that they can say if something isn't a good choice for them and not feel like they're being bowled over by adults.

This is what we call the shared decision-making process. It's really important for the teen and also the parent to give their perspective and their past experiences and to share what's important to them about the outcome. But it's also important for me to observe what I think will happen, and there are times when I say, "Hey, I know you're coming and asking me for a pill for your period or for birth control, and you just told me that you don't like using a calendar, and you can't remember to pack your backpack with your pads. How do you think you'll do with taking a pill every day and remembering to do it every day on time?" And I might observe that that might not be the best option for them.

Dr. Ramnarine:
Finally, Dr. Baldwin, looking at the adolescent population as a whole, what challenges continue to limit the use of long-acting reversible contraceptive methods, and how can clinicians help bridge the gap between guideline recommendations and real-world practice?

Dr. Baldwin:
I think, first of all, the teen needs to know about what their options are to be able to come and ask for them. And that might include just knowing generally what options are for both period management and birth control and what they are like. And so we have great websites going over those options that are a little bit more geared toward adults, but are still very informative.

And we have the ability to provide the information preemptively in clinic—so having pediatricians and primary care providers being able to say, "Hey, I know you might not feel ready for this now, but there are all these options that exist. So if you feel like you want to talk about it, come back to me later." I think that preemptive, opening-the-door-for-the-conversation comment is really helpful, and that's something that educators and coaches and other people in the community can provide as well. It doesn't have to just be in the healthcare environment. So improving education from the get-go.

And then, in terms of improving the access, having the ability for teens to make their own appointments—for them to understand how to navigate making appointments and to advocate for themselves—is a really important part of what the healthcare administrative structure can really work on. Right now, we have a lot of online access to appointments, and sometimes that's accessible to teens, and sometimes it's not. So that's an area that I think needs a little bit more improvement.

And then finally, improving the access to knowledge. We mentioned pain medication options. What are the options for the experience? That would be, I think, something that we could improve on, and that's something that a lot of clinics are focused on. And I'll just mention that Planned Parenthood clinics are very accessible to teens. Teens can schedule there on their own, and they can also get more information about different pain management options through those clinics.

Dr. Ramnarine:
That's a great comment for us to think on as we come to the end of today's program. And I'd like to thank my guest, Dr. Maureen Baldwin, for sharing her insights on how to navigate conversations about long-acting reversible contraception with adolescents. Dr.

Baldwin, it was great having you on the program.

Dr. Baldwin:
Thank you very much.

Dr. Ramnarine:
For ReachMD, I'm Dr. Shelina Ramnarine. To access this and other episodes in our series, visit *Advances in Women's Health* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.