THE PERSON THAT ASKS THE QUESTION CONTROLS THE CONVERSATION: COLLEGE STUDENTS' PRIVACY MANAGEMENT WITH PHYSICIANS ABOUT SEXUAL BEHAVIOR

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Submitted to the faculty of the University Graduate School
in partial fulfillment of the requirements
for the degree
Doctor of Philosophy
in the Department of Communication Studies,
Indiana University

September 2019

Accepted by the Graduate Faculty of Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ACKNOWLEDGEMENT

Throughout the journey of writing this dissertation, I have been supported and encouraged by individuals in my personal and professional communities. First, I want to sincerely thank the members of my research committee, Drs. Sandra Petronio, Jennifer Bute, Krista Hoffmann-Longtin, and Peter Schwartz. I would also like to thank Dr. Maria Brann, who served on my advisory committee, and gave me valuable feedback.

I am grateful for all of my teachers and mentors who have educated and socialized me into the field of communication, and who helped me develop my own priorities and identity in the field. Thank you also to my colleagues Diana Ebersole, Nicole Johnson, and Daniel Youngjoon Park, and the women of the Branch Ranch who supported me.

Thank you to my first teachers, my parents, Dr. Ernesto Hernandez and Margaret Hernandez, and brother, Tomas Hernandez. You gave me my perseverance and the skills I needed to finish this project.

Thank you to my fiancé, Kyle Werner, who helped me find joy both inside and outside of the dissertation project, and thank you to Bouchon Hernandez for your companionship during the writing process.

Finally, I owe a significant debt to the participants of this study, whose honesty and vulnerability provided valuable insights into an important aspect of physician-patient communication.

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THE PERSON THAT ASKS THE QUESTION CONTROLS THE CONVERSATION: COLLEGE STUDENTS' PRIVACY MANAGEMENT WITH PHYSICIANS ABOUT SEXUAL BEHAVIOR

College students demonstrate a persistent lack of knowledge about safe sexual practices and engage in sexual behavior that puts them at risk for preventable health issues, specifically, sexually transmitted infections and unplanned pregnancy. Fortunately, physicians have an opportunity to provide accurate and timely information about safe sexual behavior to individuals in their care. However, many young people, and in particular young women, are reticent to talk to their physicians about sexual behavior because they typically consider the information to be private. They draw thick privacy boundaries around this information, leading to a missed opportunity to communicate about sexual behavior with their healthcare provider. Exacerbating this issue is the fact that many physicians are also uncomfortable discussing sexual topics with their patients. In this dissertation, Communication Privacy Management (CPM) theory is used to investigate the criteria that female college students employ to negotiate the disclosure and concealment of information about sexual behavior to physicians. Qualitative analysis of open-ended interviews with female college students were used to describe and explain the way college students perceive issues concerning disclosure of sexual behaviors to their physician. These findings have the potential to improve communication interventions both for female college students and healthcare professionals.

Sandra Petronio, PhD, Chair

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Chapter 1: Introduction

College students are more likely to engage in risky sexual behavior than individuals in any other stage of the lifespan (American College Health Association, 2016; "College Health and Safety," 2016; Oswalt & Wyatt, 2013; Sprecher, Harris, & Meyers, 2008; Weinstock, Berman, & Cates, 2004). This risky sexual behavior can result in negative health outcomes, including unplanned pregnancy and sexually transmitted infections (STIs) (American College Health Association, 2016; "College Health and Safety," 2016). Female college students are at particular biological and social risk for the negative consequences of risk behavior. These negative outcomes are preventable, and physicians can play an important role in education and encouragement of condom use and responsible sexual behavior (Burstein, Lowry, Klein, & Santelli, 2003). However, college students often place a thick boundary around information about sexual behavior, at the expense of learning important information about sexual health. For example, college students often miss the opportunity to receive testing and treatment for sexually transmitted infections (STIs) and pregnancy prevention (Barth, Cook, Downs, Switzer, & Fischhoff, 2002; Burstein et al., 2003; Eisenberg, Garcia, Frerich, Lechner, & Lust, 2012). Communication Privacy Management (CPM) (Petronio, 2002) theory provides a way to understand how and why college students manage their private information about sexual behavior. The following dissertation outlines a study exploring privacy management with physicians about sexual behavior using open-ended qualitative interviews with female college students.

Rationale

College student risk behavior. In comparison to those not enrolled in college, college students are more likely to engage in risky sexual behavior (Oswalt & Wyatt, 2013), such as having multiple sexual partners and having sex under the influence of alcohol (Sprecher et al., 2008; Weinstock et al., 2004), as well as inconsistent condom use (Oswalt & Wyatt, 2013). Females in particular are disproportionately affected by STIs (American Sexual Health Association. 2019).

Although the risks of sexual activity can be mitigated through protective sexual health practices, a significant number of college students do not take advantage of methods to avoid unintended pregnancy and transmission of STIs, including oral birth control, intra-uterine devices (IUDs), diaphragms, and male condoms ("College Health and Safety," 2016). One reason that college students do not seek out help is a lack of understanding about STIs (E. Moore & Smith, 2012; R. Smith, Hernandez, & Catona, 2014), correct condom use (E. Moore & Smith, 2012), and birth control (Küçük, Aksu, & Sezer, 2012; Russo, Miller, & Gold, 2013; Yen, Parmar, Lin, & Ammerman, 2015). For example, college students have been shown to hold misperceptions surrounding humanpapilloma virus (HPV) (R. Smith et al., 2014) and also hold incorrect beliefs that relational intimacy can protect against STIs (O'Sullivan, Udell, Montrose, Antoniello, & Hoffman, 2010). This misunderstanding is made worse by the fact that most college students would prefer to learn about contraceptives and prophylactics from their physician, but do not ultimately broach this topic with them (Harper, Brown, Foster-Rosales, & Raine, 2010). Consequently, there has emerged a trend in high rates of

unplanned pregnancy and STIs among college students (American College Health Association, 2016; Fielder, Walsh, Carey, & Carey, 2014; Weinstock et al., 2004).

Communication about sexual behavior. College students report that they are more likely to get information about sexual health from their peers and from online sources than from their parent or healthcare professionals (Sprecher et al., 2008). For college students, peers are the most readily available resource for models of sexual communication and other sex-related behaviors (Sprecher et al., 2008). However, peer communication about sexual behavior has the potential to circulate incorrect or incomplete information about safe sex practices (O'Sullivan et al., 2010; R. Smith et al., 2014), and perceived norms of unsafe sexual activity among college students has the potential to encourage risky sexual behavior (Baumgartner, Valkenburg, & Peter, 2011; Scholly, Katz, Gascoigne, & Holck, 2005). Alternatively, healthcare professionals have the opportunity to educate their patients about methods to avoid the negative consequences of sexual activity.

Exacerbating a lack of accurate knowledge and incorrect beliefs about sexual health is the fact that female college students tend to define sexual behaviors as private. Communication with healthcare professionals is necessary for students to receive sexual health care and can provide access to resources that can prevent problems in the future. Open communication about sexual behavior is particularly challenging in this context because college students consider the information to be private, and physicians often find it difficult to discuss these issues. Research demonstrates that both physicians and patients experience discomfort in communicating about sexual health, and are aware of each other's discomfort (Burd, Nevadunsky, & Bachmann, 2006; Hinchliff, Gott, &

Galena, 2005; Lewis, Matheson, & Brimacombe, 2011; Verhoeven et al., 2003; Wimberly, Hogben, Moore-Ruffin, Moore, & Fry-Johnson, 2006). These roadblocks on both sides decrease the likelihood that college students are able and willing to engage in an open discussion about their sexual behaviors with physicians. As a consequence, there are missed opportunities to gain important information about sexual behavior in the physician-patient interaction (Barth et al., 2002; Eisenberg et al., 2012). In light of these issues, a better understanding about the factors that impede or facilitate open communication between physician and patient is needed.

A significant element of improving physician-patient communication is learning more about how college students view talking with physicians about private information related to sexual health. Because privacy is a driving motivator which limits or encourages sharing information with physicians, this study uses Communication Privacy Management theory (Petronio, 2002). This theory posits that private information is guarded by privacy boundaries that determine when others can have access to that private information (Petronio, 2002). Extant research shows that privacy boundaries about sexual behavior are guided by privacy rules (e.g. avoiding risks of disclosure about sexual behavior) (Ackard & Neumark-Sztainer, 2001; Burd et al., 2006; Fuzzell, Fedesco, Alexander, Fortenberry, & Shields, 2016; Metz & Seifert, 1990; Petronio, 2002). The following study identifies college students' privacy rules for discussion of sexual topics with physicians and the criteria they use to develop these rules. Because privacy is a driving motivator that limits or provides information to a physician, this study uses the lens of Communication Privacy Management theory (Petronio, 2002).

Dissertation Study

Research questions. Guided by the theory of Communication Privacy Management theory, this study addresses female college students' sexual risk behavior and communication with physicians via the following research questions:

R1: How do female college students decide to whom, where, and how much private information is shared with healthcare professionals about sexual behaviors?

R2: What are the privacy rules female college students use when managing private information about sexual behavior with healthcare professionals?

Data collection. Previous studies exploring sexual health communication between young people and their physicians have employed secondary analysis of national survey data, review of audio and videotapes of actual patient encounters, and questionnaires (Alexander et al., 2014; Burstein et al., 2003; Epstein et al., 1998; Fuzzell et al., 2016; Lewis et al., 2011; Metz & Seifert, 1990). Building on this literature, interviews exploring why and how female college students decide to open a privacy boundary with a physician can give insights into the subjective perspective of the patient. Qualitative explorations of communication between physicians and college students have the potential to uncover innate complexities regarding privacy management about sexual behavior. In this study, participant responses can provide deeper insights into this communicative phenomenon. These interviews have the potential to provide details and make links which otherwise might not have emerged simply through surveys or highly structured interviews, as well as creating a more private and confidential space than the use of focus groups (Tracy, 2012). Further, gathering perceptions about this communication from the perspective of the patient avoids assumptions that it is the

physician who dictates the communication. Instead, this approach gives the patient the power to articulate their experiences in their own voice.

A pilot study served as formative research to tailor the interview protocol and other aspects of the dissertation study. Then, a semi-structured interview protocol uncovered specific privacy rules and the factors that participants used to create privacy rules. The protocol contained high-priority questions delineated in bold and probing questions highlighted in grey text to guide the interview process and allowed the interviewer to prioritize the interview questions given time constraints and the flow of discussion. Qualitative research can create a space where people can "warm up" to sharing sensitive topics, and thus uncover "guarded worlds" (Tracy, 2012, p. 5). For example, in this interview protocol, participants were first asked to answer less-threatening questions, become comfortable, and then open up about more sensitive topics (Tracy, 2012).

This dissertation study consists of interviews with open-ended questions addressing privacy rule criteria, and resulted in findings that address specific privacy rules regarding communication about sexual behavior. Participants were purposively selected, and female college students between the ages of 18-26 were included in the study. These selection criteria were based on research findings that demonstrate female college students' biological and social sexual health risk. Further, extant research suggests that women's experiences with physician-patient communication about sexual behavior differ in important ways from men (Alexander et al., 2014; Barth et al., 2002; Metz & Seifert, 1988).

After the study achieved IRB approval, college students at an urban, mid-western university were recruited to participate in the study. Individual, open-ended interviews were conducted in a private space on campus and lasted approximately one hour. The data collected for this study consist of notes and memos taken during the interview process, and the transcribed interview responses of the participants (Charmaz, 2006). Using the software Dedoose, the data were analyzed line-by-line (Charmaz, 2006), and primary and secondary-cycle coding were used to categorize patterns in data, and then develop a theory about the relationship between these categories (Tracy, 2012), resulting in a parsimonious explanation of privacy rules and criteria for female college students' discussion of sexual behavior. The findings were interpreted through the lens of Communication Privacy Management theory, weaving the research findings with the tenets of the theory of CPM.

Contribution of the study to theory and practice. This project builds communication theory by using Communication Privacy Management theory to examine college student privacy management about sexual behavior. Physician-patient communication about sexual behavior should be examined through a theoretical lens that does not treat private information as a singular transmission (Burd et al., 2006; Epstein et al., 1998), as a binary between "honesty" and "lies" (Iezzoni, Rao, DesRoches, Vogeli, & Campbell, 2012; Tuckett, 2004), or treating the physician as dominant in the interaction (Burd et al., 2006; Coverdale, Balon, & Roberts, 2011; Epstein et al., 1998). Further, the author builds on published authored (Hernandez, 2018) and co-authored work exploring disclosures about STIs (R. Smith et al., 2014) and other taboo topics (Ebersole & Hernandez, 2016), as well as research exploring physician cognition (Hernandez, 2018a;

Hernandez, Haidet, Gill, & Teal, 2013) to create a theoretically-driven understanding of how emerging adults in college manage their private information about sexual behavior with their physicians.

Regarding contributions to practice, there is a clear opportunity to improve the sexual history interview between healthcare provider and patient. Research shows that patients need and want to open communication about sexual behavior, and yet generally, physicians' communication about sexual behavior needs improvement. Currently, medical students receive little or no training on how to communicate about sexual history (Coleman et al., 2013; Fuzzell et al., 2016; Tsimtsiou et al., 2006). While communication training about sexual behavior is a stated requirement for medical school accreditation by the Liaison Committee on Medical Education (LCME), this training is unstandardized, and the quantity and quality of training varies widely (Shindel & Parish, 2013). Further, while patients expect their physician to provide leadership in discussions about sexual health, it is unclear which communicative features college students would consider "best practices" in the sexual history interview. Further, female college students may have communication preferences that differ in important ways from male students. Sparse training in this communication gives rise to the opportunity to create patient- and relationship-centered communication interventions which privilege the preferences of the patient, while giving physicians the skills they need to feel confident in the encounter.

Dissertation overview. The following dissertation chapters first provide a review of the research literature, then describe the methods of this study, explain the results, and discuss the findings. Chapter 2 outlines the research literature examining female college students' risk behavior, physician-patient communication about sexual behavior, and the

theory of Communication Privacy Management. Chapter 3 describes the study data collection and the approach to data analysis. Chapter 4 explains the results of the study, and Chapter 5 discusses the conclusions, recommendations for practitioners, and directions for future research.

Chapter 2: Literature Review

Healthcare professionals have an opportunity to interact with patients and provide accurate and timely information about safe sexual behavior to individuals in their care. Unfortunately, both physicians and patients are reticent to talk about sexual behavior. Communication about sexual behavior between patients and physicians involves managing private information. In light of the importance of private information in this context, the literature review first explains how the theory of Communication Privacy Management is a fitting lens through which to understand this phenomenon.

Then, the literature review discusses how young people's health risk behavior has been demonstrated to have significant effects on both the health of individuals, and, on a larger scale, in the United States healthcare system. Next, an explanation about the prevalence of these risk behaviors in certain sub-groups is discussed. Specifically, demographic factors, such as college attendance, gender, sexual orientation, and stage in the lifespan (i.e. emerging adulthood) are associated with higher levels of risk behavior. In particular, individuals in the age group of emerging adults experience meaningful differences in physical, cognitive, and social-emotional status related to sexual behavior (Slater, 1995). Next, the literature review discusses extant research exploring how college students learn about safe sexual behavior via communication with different sources. These sources include parents, peers, resources on college campuses, and physicians. In particular, communication with physicians has the potential to provide accurate, timely, and persuasive information about safe sexual behavior (Alexander et al., 2014; Burstein et al., 2003; Hopfer & Clippard, 2011).

Next, the literature review provides evidence that both patients and physicians are uncomfortable communicating about sexual behavior, and that this discomfort translates into fewer conversations about sexual behavior and lower quality conversations about sexual behavior (Alexander et al., 2014; Epstein et al., 1998; Wimberly et al., 2006). Some of the factors that may create discomfort include physician and patient gender, and communication factors such as physician embarrassment, communication strategies, nonverbal behaviors, and implicit bias. Finally, the review discusses a recent movement in the research field of physician-patient communication to emphasize the preferences of the patient, encouraging patient-centered communication.

Communication Privacy Management Theory

Understanding how college students communicate with physicians about sexual behavior can be enhanced by using the theory of Communication Privacy Management. CPM is a theory grounded in empirical evidence that explores how individuals communicatively manage private information (Petronio, 2002, 2007, 2013). Through a rules-based management system, individuals must decide whether and how to open or close a privacy boundary (Petronio, 2002, 2007, 2013). This process of opening and closing boundaries allows individuals to balance the dialectical tension of the need to be open with others and receive the benefits of that openness, with the need for privacy and autonomy (Petronio, 2013). For example, college students must balance the vulnerability of opening up about their sexual concerns in order to receive the benefits of prevention and treatment.

CPM is comprised of axioms of managing private information (Petronio, 2013). First, individuals believe they own their private information (Petronio, 2013). This belief

of information ownership is the engine that drives the process of privacy management (Petronio, 2013). This ownership of private information delineates a line, a metaphorical boundary between public and private (Petronio, 2013). When the metaphorical boundary is very thin and permeable, individuals are more likely to disclose private information (Petronio, 2013). When a boundary is thick, the line between public and private is impermeable, and the information is heavily guarded (Petronio, 2013). For college students, information about sexual behavior is surrounded by a thickly drawn, well-protected boundary. However, at times, individuals open a privacy boundary allowing other access to the private information, thereby bestowing co-ownership of that information to others (Petronio, 2013).

Because a discloser expects to maintain control over their private information, when another individual gains access to private information, the confidant assumes co-ownership of information, and thus, the responsibility to control the information (Petronio, 2013). Granting co-ownership is naturally associated with some risks, and to manage those risks, individuals construct a rules-based management system to regulate the flow of private information (Petronio, 2013). The rules in this management system prescribe to whom, where, and how much private information is communicated (Petronio, 2013).

The opening of a privacy boundary has consequences for both the discloser and the confidant (Petronio, 2002). Information owners presume that the selected authorized co-owner will follow existing boundary rules, develop new boundary rules, and negotiate new rules with third parties (Petronio, 2002). At times, co-ownership of information may result in jointly guarded boundaries, where both individuals contribute private

information within the boundaries (Petronio, 2002). Collective boundaries are maintained over time via decisions about third-party access to the information (Petronio, 2002).

Finally, human communication is flawed, and these processes do not always unfold perfectly. At times, confidants may violate rules about the management of private information (Petronio, 2002). When these violations occur, boundary turbulence arises (Petronio, 2002). This turbulence has the potential to disrupt relationships and guide future decision about to whom to open a privacy boundary (Petronio, 2002).

Individuals develop privacy rules based on criteria such as motivational criteria, contextual criteria, risk-benefit ratio criteria, cultural criteria, or gender criteria (Petronio, 2002). In other contexts, risks such as embarrassment and stress, contextual criteria surrounding urgency (Ebersole & Hernandez, 2016), beliefs about societal privacy rules (Bute, Brann, & Hernandez, 2017), and risk factors such as stigma and communication efficacy (Steuber & Solomon, 2011), were found to foment resistance to opening up about private topics. In the language of CPM theory, these criteria may also encourage a thick privacy boundary around sexual topics in communication with physicians. Finally, decision-making criteria can either remain stable over time (known as core criteria), or may change due to a shift in external factors (catalyst criteria) (Petronio, 2013). For example, college students may draw on a cultural core criterion to keep all information about sexual behavior private. However, emergent circumstances may trigger risk-benefit catalyst criteria for opening a privacy boundary, such as urgent concerns about a pressing sexual health issue. Understanding these criteria and privacy rules are integral to decoding the obstacles and facilitators of communication about sexual behavior with a

physician. The following section will focus on the role of privacy in physician-patient communication about sexual behavior.

Healthcare providers, patients, and privacy. As sexual information is generally considered private, patients must make decisions about when to share, and when to avoid or conceal sexual topics with their healthcare provider. Research shows that patient privacy decision-making leads to a generally thick privacy boundary surrounding private information about sexual behavior. As a result, interactions between physicians and patients regarding sexual behavior have not reached their full potential to attenuate potential risk behavior among patients by providing testing and treatment for STIs, condoms, and prescriptions for birth control (Althof, Rosen, Perelman, & Rubio-Aurioles, 2013; Barth et al., 2002; Burstein et al., 2003). These decisions are based on privacy management criteria including context, gender, culture, motivations, and risk-benefit ratio.

The theory of CPM describes how gender plays a role in decision-making about privacy rules (Petronio, 2002). Patient and physician gender may serve as a gendered criterion for privacy management, and male and female patients' experiences of communication with physicians about sexual behavior differ in important ways, such as their preferences for physician communication strategies (Burd et al., 2006; Roter, Hall, & Aoki, 2002). Exacerbating this issue is the fact that both patients and a majority of physicians reported experiencing discomfort with communication about sexual behavior (Althof et al., 2013; Bull et al., 1999; Epstein et al., 1998; Hinchliff et al., 2005; Verhoeven et al., 2003). In the primary care setting, social elements such as a risk of embarrassment, appearing incompetent, and a lack of communication training were found

to be integral to reticence on the part of the physician (Verhoeven et al., 2003). In the language of CPM, these social elements inform a risk-benefit rule development criterion, wherein the risk of experiencing embarrassment closes a privacy boundary. Another investigation found that other communication factors such as taking the perspective of the patient and smooth introduction of the topic of sexual behavior (without hesitations or reformulations) encouraged more open communication with the patient (Epstein et al., 1998). The nonverbal behaviors signal physician comfort with communication about sexual behavior, encouraging the patient to open a privacy boundary. A recent study found via self-reported surveys that patients were more likely to open up when they perceived a sense of friendliness, a lack of hurriedness, the physician's use of a first-name introduction, and open-ended questions (Lewis et al., 2011).

These and other studies show that patients both perceive and experience physician's discomfort with communicating about sexual behavior, and use this as a criterion for building privacy rules (Alexander et al., 2014; Barth et al., 2002; Epstein & Street, 2011; Fuzzell et al., 2016; Lewis et al., 2011). Physicians reported other barriers to communication as well, including beliefs about adolescents' inaccurate information about their sexual behavior (Henry-Reid et al., 2010), concerns that have been confirmed by research showing that patients either modify or withhold information about their sexual behavior (Lewis et al., 2011). These studies show that physicians are reluctant to solicit private information about sexual behavior if they believe that the patient will not only disclose partial information about their behavior.

Physician bias may also affect communication between healthcare providers and patients. Physician discomfort with communication has been reported specifically with

minority populations, creating a potential cultural criterion for patients deciding whether to share their private information. These patients likely need the services of physicians the most, and yet are less likely to receive care. This unease with discussing sexual issues was also reflected in the reported experiences of sexual minority patients (Fuzzell et al., 2016).

Even if given the opportunity to discuss a sexual history and sexual concerns, some patients still hold back some specific private information. Research suggests that patients seeking care for sexual health will conceal or only share partial information about their sexual practices (Bilney & d'Ardenne, 2001; Lewis et al., 2011; Rose et al., 2009). Female patients at a birth control clinic were asked if they concealed or limited information about their sexual history (Lewis et al., 2011). Half of the women who responded to the questionnaire either altered or withheld information about their sexual behavior (Lewis et al., 2011). Specifically, condom use history and number of sexual partners were two topics that were either altered or avoided in the healthcare interview (Lewis et al., 2011). Another exploration of the discrepancy between self-reported condom use and actual use found discordance with approximately a third of female respondents (Rose et al., 2009). This study used a questionnaire to collect self-reports of condom use from the past 14 days from female participants (Rose et al., 2009). The researchers then used a biological test to detect the presence of sperm in the last 14 days (Rose et al., 2009). Of those participants who reported 100% condom use in the past 14 days, the presence of sperm revealed a statistically significant discordance with participants self-reports of condom use (Rose et al., 2009).

These findings reveal that patients make decisions about what and how much private information to reveal to their healthcare professional, and that these decisions can subvert necessary medical treatment. When patients' assessment of the physician results in the decision to close a privacy boundary, there are potential health-related consequences. If a patient conceals a number of sexual partners or risk practices, then the physician might be unable to assess what resources the patient needs to avoid pregnancy and STIs, or what tests or treatments to recommend. Understanding why and how patients develop these privacy rules is integral to ensuring that women receive the healthcare they need.

Research focusing on patients' privacy has explored different aspects of physician-patient communication. Much of the extant research focuses on whether the physician asked a particular set of questions (e.g. items on a checklist), issues of confidentiality (Lehrer, Pantell, Tebb, & Shafer, 2007; Parrott, Burgoon, Burgoon, & LePoire, 1989), or the nature of the physician's questions (e.g. whether physicians' questions were open-ended) (Griffith III, Wilson, Langer, & Haist, 2003). Some research has explored how physicians may disclose their own private information to a patient (Beach, Roter, Larson, et al., 2004; Beach, Roter, Rubin, et al., 2004; McDaniel et al., 2007; Petronio, DiCorcia, & Duggan, 2012). For example, in conversations with patients, physicians may open up about their emotions, share information about their families, or share personal information about their own experiences related to the patients' diagnosis (Beach, Roter, Larson, et al., 2004; Beach, Roter, Rubin, et al., 2004; McDaniel et al., 2007; Petronio et al., 2012).

The multifaceted problems surrounding college student privacy management about sexual behavior would benefit from viewing privacy through a lens that does not treat private information as a singular transmission (Burd et al., 2006; Epstein et al., 1998), or as a binary between "honesty" and "lies" (Iezzoni et al., 2012; Tuckett, 2004). Even the common phrase of "taking a sexual history" implies a unidirectional transmission of communication, elicited from the patient by the physician (Coverdale et al., 2011). The CPM approach to this research would complement and engage with new paradigms of patient-centered communication, as it emphasizes interactions, and does not necessarily place a universal value judgment on the opening or closing of a boundary. Further, in the medical literature, terms such "honesty" are at times used to describe these processes (Iezzoni et al., 2012), whereas CPM focuses specifically on the issue of private information, and highlights the communicative process. Finally, the literature on doctor-patient communication about sexual behavior reveals that the chasm between physician and patient in communication about sexual health is often created by "rules" (e.g. physician gender), and "strategies" (e.g., allowing the physician to lead the conversation about sexual health) (Burd et al., 2006; Wittenberg & Gerber, 2009).

In light of this research, this study uses the theory of Communication Privacy Management (CPM) as a lens to understand these communication phenomena. Gaps in communication about sexual behavior have contributed to health risk behavior among college students, and in particular, female college students. This risk behavior has had deleterious effects on the health of individuals, and, on a greater scale, in the healthcare system.

The Effects of College Student Risk Behavior

In general, college students engage in risky sexual behavior that makes them vulnerable to sexually transmitted infections and unintended pregnancy. Relatively high rates of unintended pregnancy and sexually transmitted infections (STIs) in this group have both significant large-scale consequences on the Unites States healthcare system, as well as individual consequences.

Unintended pregnancy. Unintended pregnancies come with both high costs to the United State healthcare system (Peipert, Madden, Allsworth, & Secura, 2012) as well as personal consequences (Forrest, 1994; Gipson, Koenig, & Hindin, 2008; Logan, Holcombe, Manlove, & Ryan, 2007; Schwarz, Smith, Steinauer, Reeves, & Caughey, 2008). A recent analysis of unintended pregnancies in college age groups the United States found that 76% of pregnancies in the age group 18-19 were unintended (approximately 305,000 total), and 64% of pregnancies in the age group 20-24 were unintended (approximately 878,000 total) (Finer & Zolna, 2016). Total public expenditures on unintended pregnancies nationwide were estimated to be $21.0 billion (Finer & Zolna, 2016).

On an individual level, unintended pregnancies that lead to childbirth can hold potential consequences for the health of both the child and the parent. For example, unintended pregnancy is associated with behaviors that have the potential to impact infant health (e.g. smoking and breastfeeding), as well as the life of a child as they mature into adolescence and adulthood (e.g. educational outcomes) (Logan et al., 2007). Unintended pregnancy can also have deleterious effects on the mental health of the mother (Logan et al., 2007).

Recent data indicates that approximately 40% of all unintended pregnancies end in abortion (Finer & Zolna, 2016). Women enrolled in college were most likely to end an unintended pregnancy with abortion (Finer & Zolna, 2016). While there is no conclusive evidence of widespread long-term negative effects of abortion (Boonstra, 2006), there are avoidable short-term negative consequences. For example, the process of acquiring an abortion can create challenges for many women. Of those women who opt to have an abortion, approximately one in four travel 50 miles, which can prevent women from receiving timely care, complicating their treatment (Henshaw & Finer, 2003). In addition to the negative effects of unplanned pregnancy, risky sexual behavior can lead to the spread of sexually transmitted infections (STIs).

Sexually transmitted infections. The transmission of STIs between young people is of major concern for public health professionals (Sprecher et al., 2008). One estimate of the overall public and private direct costs of STIs in the United States was $6.5 billion (Chesson, Blandford, Gift, Tao, & Irwin, 2004). In comparison to other age groups, college students are more likely to be diagnosed with an STI (Kaiser Family Foundation, 2014). While only a quarter of the sexually-active population is under the age of 25, young people under the age of 25 comprise most new diagnoses of gonorrhea, and chlamydia every year (Kaiser Family Foundation, 2014). If left untreated, these STIs can result in serious consequences, such as infertility, pelvic pain, pelvic inflammatory disease, and cancer ("College Health and Safety," 2016). Individuals between the ages of 20-24 also make up the highest number of all new diagnoses of HIV (Hess et al., 2018). Due to social and biological factors, certain sub-groups of college students, such as

women and individuals with a minority sexual orientation are at higher risk for these negative consequences.

Sexual Health Risk Factors

Gender and biological sex. Societal, interpersonal, and biological factors situate women in particular at higher risk for the negative consequences of sexual behavior. It is important to note that societal norms generally frame women as responsible for contraception (e.g. hormonal birth control) (Fennell, 2011). While this study does not subscribe to this perspective, it is the case that most current methods of birth control are in the woman's domain. However, while a woman may exert control over some forms of contraception, women may experience barriers to consistent condom use with sexual partners. For example, the weakened ability to negotiate condom use with their partner is one interpersonal risk factor some college women face (Pulerwitz, Amaro, Jong, Gortmaker, & Rudd, 2002; Roberts & Kennedy, 2006). Other studies have shown that some women struggle in particular with the self-efficacy to insist on condom use with a male partner (Farmer & Meston, 2006), resulting in either no or inconsistent condom use (Gómez & Marin, 1996; Wulfert & Wan, 1993). This low self-efficacy to insist on condom use may be a result of holding less power in relationships (Pulerwitz et al., 2002). Further, conservative societal norms constraining women's sexual behavior may reduce the likelihood of practicing safe sex (S. Moore & Rosenthal, 1992).

In addition to these social factors, a woman's anatomy predisposes her to a higher risk for contracting STIs ("Women and STIs," 2019). STIs are more likely to be transmitted from men to women than from women to men, in part due to a greater exposure surface area in the vagina compared to the penis, the sensitivity of the

membrane in the female genital tract, and the tendency of the genital tract to retain infective secretions (Tarr & Gilliam, 2008; "Women and STIs," 2019). For example, one early study found that the likelihood of a women contracting gonorrhea during intercourse with an infected partner ranges from 60% to 90% (Judson, 1990). In contrast, men's risk of contracting gonorrhea during intercourse with an infected partner is approximately 20% to 30% (Judson, 1990). Additionally, STIs such as chlamydia and gonorrhea are largely asymptomatic in women when compared to men (Mayor, Roett, & Uduhiri, 2012). However, there are some exceptions; there is currently no diagnostic test for HPV in men ("STD Facts - Human papillomavirus (HPV)," 2017). Because they are less likely to experience symptoms of an STI, women may delay seeking medical attention ("Women and STIs," 2019), and as a result are more likely than men to develop complications, such as infertility ("Women and STIs," 2019).

Sexual orientation. Sexual health risk factors can also be traced along lines of sexual orientation and identity (Oswalt & Wyatt, 2013). A national sample of college students revealed that while the majority (94%) of respondents identified as heterosexual, students who reported minority sexual identities were even more likely to engage in risk behavior than others (Oswalt & Wyatt, 2013). Male students who self-identified as "unsure" of their sexuality were more likely than those who identified as gay, bisexual, and heterosexual to have had sex in the previous 30 days, and also reported a higher number of sexual partners in the previous 12 months than other groups (Oswalt & Wyatt, 2013). Bisexual women similarly reported having significantly higher number of partners than college students who identified as other sexual orientations (Oswalt & Wyatt, 2013). However, general sexual risk trends across all sexualities were high; risky

sexual behavior was extant among gay and heterosexual students alike (Oswalt & Wyatt, 2013). These results make evident that minority sexual groups are at highest risk, however, across sexual identity and orientation, college students generally engage in risky sexual behavior.

Emerging adults attending college. Health communication research often segments a population by a specific age group (Slater, 1995). Grouping a sample by age is presumed to indicate meaningful differences in physical, cognitive, and social-emotional status (Slater, 1995). However, there has been a recent upheaval in the categorization of life stages. A proposed new stage (new in both theorization and emergence in the population) suggests that bounds should be drawn around a phase called emerging adulthood. Proponents of this stage argue that occurring after adolescence (ages 10-18) and before young adulthood, there is an important yet neglected phase. This phase (ages 18-25) is called emerging adulthood (Arnett, 2000; Arnett, 2014), and encompasses a large segment of the population of individuals attending college. In fact, 19.9 million students are enrolled in college in the Fall of 2018, and females account for the majority of these college students ("National Center for Education Statistics Back to School Statistics," 2018). Arnett (2000, 2014) resists the term "late adolescence," to characterize the stage from ages18- 25, the stage when many individuals attend college. While many studies focus on ages 18-25, the upper limit of emerging adulthood varies, and can reach to age 29 (Arnett, 2014).

Traditionally, the transition from adolescence to adulthood is classified as passage through five milestones. To transition to adulthood, an individual must finish their education, leave the home, reach financial independence, get married, and have children.

However, modern rates of passing the milestones are delayed compared to past demographics. Data from the United States Census Bureau shows that in the year 1960, by the age of 30, 77 percent of women and 65 percent of men had passed all five milestones (Henig, 2010). In the year 2000, these milestones had been reached by less than half of women and one third of men (Henig, 2010). These data indicate that there is an important change fomenting in adolescents approaching adulthood. These changes prompted the proposal of the new stage, called emerging adulthood.

In the U.S. and other developed countries, recent trends reveal the postponement of marriage and age of first childbirth, the need for more education in an information-based economy, and consequently, the explosion of young people entering higher education (Arnett, 2000, 2014). Arnett (2000, 2014) characterizes emerging adulthood as the age group wherein individuals face identity exploration, self-focus, instability, feel in-between, and the sense of new possibilities. He argues that unlike ages 12-18, where the vast majority of peers are unmarried, childless, and in school, normative roles for individuals in this age range are unclear (Arnett, 2000, 2014). This uncertainty marks a period of time when emerging adulthood experience instability (Arnett, 2000, 2014). Notably, these unstable social factors create a context where risky sexual behavior can increase (DiClemente, 1991; Scholly et al., 2005). The signs of emerging adulthood may also be found beyond social factors; neuroscience may contain insights into this life stage.

In studies of the developing brain, magnetic resonance imaging provides insights into how the brain develops over the lifespan. A longitudinal NIH study of the brain found that brains do not fully mature until the age of 25, and may mature even beyond the

age of 25 (Giedd, 2004). The study also revealed that of the many changes in the brain, the most important ones occurred in the areas that manage emotions and higher cognitive function (Giedd, 2004). Importantly, these areas are particularly useful in communication about sexual health and negotiating safe sexual practices, such as understanding and interpreting a partner's preferences for contraception, as well as asserting one's own preferences. Other risk behaviors such as alcohol and illegal drug-use are prevalent during this time in the lifespan, exacerbating problematic sexual practices (Johnston, O'Malley, Bachman, & Schulenberg, 2011). During this in-between time, not only are brains still maturing, but young adults may have underdeveloped personal resources, as well.

In addition to contextual and neurological changes, emerging adulthood is also marked by an offspring's extended acceptance of resources from the parent (Furstenberg, 2010). American parents provide an average of 10 percent of their income to their 18-21 offspring, regardless of total income (Furstenberg, 2010). While college students may receive instrumental support from their parents, research shows that with regard to issues of sexual health, emerging adults are less influenced by and communicate less with their parents (Lefkowitz & Espinosa-Hernandez, 2007). In other words, emerging adults are still dependent on their parents for financial resources, but also report less communication in general. However, it is important to note that not all individuals in this stage of the lifespan attend college.

Arnett explains the differences between college attendants and non-college attendants,

> Both experience emerging adulthood as the age of identity explorations, the age of instability, the self-focus age, the age of feeling in-between, and

> the age of possibilities, although there are differences in the content of their experiences. For example, in the course of their identity explorations, college students change educational directions, while non-college emerging adults change jobs (Arnett, 2006, p. 121).

When comparing the two groups, Arnett argues that individuals who do not seek secondary education may have a shorter span of emerging adulthood and suggests that the characterization of a new stage will draw fresh attention to this population. Called "the forgotten half," individuals who did not attend residential college are vastly under-researched (Arnett, 2000). Arnett (2000) argues that the categorization of emerging adults will give researchers a paradigm that examines this phase, while including individuals who do not attend residential college. This review provides a rationale for specific examination of emerging adults in college, thus acknowledging these discrepancies.

In comparison to individuals not enrolled in college, college students are generally more likely to engage in risky sexual behavior. College is a time when students explore their sexual identity and preferences, and with experimentation comes risk behavior (Oswalt & Wyatt, 2013). For example, research suggests that approximately half of emerging adults have had their first sexual intercourse in the college years (Eisenberg, Ackard, Neumark-Sztainer, & Resnick, 2008). Further, college students are more likely to have multiple sexual partners and have sex under the influence of alcohol (Sprecher et al., 2008; Weinstock et al., 2004). And, of those students who reported engaging in sexual activity in the past 12 months, only a third reported "always" using a condom during vaginal intercourse (Oswalt & Wyatt, 2013). Female college students were also significantly less likely than male college students to report condom use during sex (Halpern-Felsher, Kropp, Boyer, Tschann, & Ellen, 2004, (Lehr, DiIorio, Dudley, & Lipana, 2000).

Physicians have a specific opportunity to talk to their female patients about safe sex practices such as condom use. However, research shows that even if given the chance to discuss sexual concerns, some patients withhold private information about sexual behavior. Preventing risk behavior in this group requires an understanding of the sources of information and influence regarding sexual behavior.

An important element of optimizing this communication is learning more about how female college students view talking with physicians about their sexual health-related information. Gaps in communication about sexual health between physicians and patients are often guided by "rules" (e.g. physician gender), and "strategies" (e.g., using transitional phrases) (Burd et al., 2006; Roter et al., 2002; Wittenberg & Gerber, 2009). Because privacy is a driving motivator which limits sharing information from physician, approaches issues of privacy from the perspective of CPM (Petronio, 2002).

Opening a privacy boundary surrounding information about sexual health has the potential to attenuate risky sexual behavior through learning about sexual health. For female college students, there are several channels through which to learn about sexual health and engage in safe sexual practices. For example, trends in college students' knowledge about sexual health reveal an opportunity to gain accurate understanding of information about sex. Further, college students' sources of communication about sexual health include parents, peers, college resources, and communication with physicians. The theory of Communication Privacy Management helps explain how privacy boundaries are opened in these different contexts.

Preventing Risk Behavior

Knowledge about sexual health. The risks of sexual activity can be mitigated through protective sexual health practices. Methods to reduce the potential harm of sexual activity include oral birth control, intra-uterine devices (IUDs), diaphragms, and male condoms ("College Health and Safety," 2016). These options allow female college students to avoid unintended pregnancy and transmission of STIs (Poppen, 1994). However, many college students remain ignorant about safe sex practices, or choose not to use them.

Despite the availability and effectiveness of protective sexual behaviors, there persists widespread lack of understanding among college students about the types, symptoms, prevalence, and treatment of STIs and correct use of contraceptives (Harper et al., 2010; E. Moore & Smith, 2012; R. Smith et al., 2014). For example, college students have been shown to hold misperceptions surrounding humanpapilloma virus (HPV), conflating HPV with HIV and cancer (R. Smith et al., 2014). Women in particular demonstrate persistent misconceptions about birth control (Küçük, Aksu, & Sezer, 2012; Russo, Miller, & Gold, 2013; Yen, Parmar, Lin, & Ammerman, 2015). These misunderstandings were revealed in a simulated phone conversation between college students and their peers, revealing that incorrect information about STIs has the potential to spread through peer communication (R. Smith et al., 2014). Another study found that college students incorrectly believe that relational intimacy can protect against STIs (O'Sullivan et al., 2010).

In general, college students also have major discrepancies in their definitions of sexual behavior (Gute, Eshbaugh, & Wiersma, 2008). For example, when describing their

own sexual activity, participants defined "having sex" as specifically "penile-anal and penile-vaginal intercourse." However, when defining their partner's behavior as having sex, they were more likely to include oral sex in this definition, in addition to penile-anal and penile-vaginal intercourse. These discrepancies complicate partner communication about their personal sexual history. For example, this inconsistency in definitions makes it difficult to interpret a partner's response to the question "how many sexual partners have you had this year?" and as a result, lead to increased sexual risk (Gute et al., 2008). Discrepancies of definitions of sexual behavior also fall along the lines of gender (Bogart, Cecil, Wagstaff, Pinkerton, & Abramson, 2000). For example, heterosexual female college students define anal sex differently than their male counterparts. Heterosexual male college students considered anal intercourse to be sexual behavior regardless of whether the male partner had an orgasm. In contrast to male college students, female college students only defined anal intercourse as sexual behavior if the male partner had an orgasm.

In another example of gaps in awareness of sexual issues, a study of women who had chosen to use hormonal contraceptives found low levels of knowledge regarding how hormones work, and the side effects of contraceptives (Harper et al., 2010). However, the women in this study generally held their physician in high regard and believed that their physician was a good source of information about health and contraception. The majority of women (80%) stated that they believe that their provider cares about them, they have trust in their provider, that they believe that their provider tells the truth about health and contraception, that their provider makes good decisions for health and contraception, and that their providers are experts (Harper et al., 2010). The study signals that healthcare

providers have the potential to play an important role in educating patients and encouraging continued use of contraceptives. However, the patients' significant lack of knowledge about contraceptives illustrates that physician-patient communication ultimately fell short in fully educating women about the details of hormonal contraceptives.

These research findings give rise to the question of how female college students can increase their knowledge and correct use of safe sexual practices. Research suggests that college students' knowledge and behavior about sexual health is often social and is influenced by interactions with others (Sprecher et al., 2008). College students have two primary sources for sexual health information: parents and peers (Sprecher et al., 2008).

Parents. The contextual change of attending a residential college triggers a shift in the sources of communication about sexual topics. In general, research demonstrates that the privacy boundary about sexual behavior between college students and parents is thickly drawn (Lefkowitz & Espinosa-Hernandez, 2007). Parents often avoid or completely eschew communication about sexual topics with their children (DiIorio, Pluhar, & Belcher, 2003). One study found that female college students were less likely to communicate about sex with their parents than male college students (Lehr, DiIorio, Dudley, & Lipana, 2000). Another study demonstrated a potential explanation for this avoidance, finding that in their sample, adolescents tell their parents that they already have adequate knowledge about sexual activity (Jaccard, Dittus, & Gordon, 2000). When a child leaves for college, a parent's ability to influence their child's behavior wanes (Lefkowitz & Espinosa-Hernandez, 2007). Over time, college students report less communication with parents and more communication with peers (Lefkowitz &

Espinosa-Hernandez, 2007). This guarded boundary reduces the potential influence parents may have on their child's behavior (Kotchick, Dorsey, Miller, & Forehand, 1999). Additionally, an early study found that parents are more likely to have behavioral influence over new college freshman in comparison to college juniors and seniors (Curtis, 1974). There is also a gender difference in parents' interpersonal influence on safe sexual behavior (Holtzman & Rubinson, 1995). Females were more likely than males to be influenced by their parents with regard to having fewer sexual partners and avoid unprotected safe sex. Another early study found that according to college students, the climate between parents and children discussing sex is more defensive than communication between peers (Rozema, 1986). These findings suggest that an important shift occurs when a child attends college, with sexual health communication transitioning from parents to peers.

Peers. Beginning in adolescence, teens begin to progressively report more private disclosures to their peers than to their parents (Buhrmester, Bukowski, Newcomb, & Hartup, 1996; Sprecher et al., 2008). Peer communication about sex is especially important for residential college students because they will spend much more face time with peers than with parents (Lefkowitz, Boone, & Shearer, 2004). Further, college students must construct meaning in novel situations, and peers are the most readily available resource (Sprecher et al., 2008). Because college students are less able to rely on prior expectations for behavior, they must be attuned to the new norms (Bull et al., 1999; Burd et al., 2006). This high ambiguity and uncertainty strengthens the influence of peer norms (Cialdini, 2001).

Peer communication about sexual behavior can have paradoxical effects. While some research suggests that peer communication can promote safe sexual behavior (Lefkowitz et al., 2004; Romer et al., 1994; Whitaker & Miller, 2000), other research found peer communication to be associated with an increase in risk behavior (Halpern-Felsher et al., 2004). For example, peer communication has the potential to disseminate misinformation about sexual health (R. Smith et al., 2014). This communication can also perpetuate misperceptions of the norms of sexual behavior in a peer group (Baumgartner et al., 2011; Scholly et al., 2005). Another study found that college students who engaged in more frequent communication about sex-related topics with close friends were also more likely to be sexually active (DiIorio, Kelley, & Hockenberry-Eaton, 1999; Lefkowitz et al., 2004). On the other hand, some research suggests that peer communication can promote safe sexual behavior (Hernandez, 2018b; Lefkowitz et al., 2004; Romer et al., 1994; Whitaker & Miller, 2000). Simply the ability to communicate about sex may improve safe sex behaviors for college students who are already sexually active (Halpern-Felsher et al., 2004). However, there are gender differences regarding peers' influence on sexual behavior (Holtzman & Rubinson, 1995). In a comparison between males and females, males were significantly more likely to be influenced by peers (Holtzman & Rubinson, 1995).

College students have privacy boundaries of varying permeability surrounding different topics. College students' peer communication about sexual behavior includes topics such as condom use (Rittenour & Booth-Butterfield, 2006), dating, behaviors and feelings, and reproductive health (DiIorio et al., 1999; Lefkowitz et al., 2004; Pistella & Bonati, 1998). One of these studies found that college students were less likely to discuss

HIV, rape, and abstinence (Lefkowitz et al., 2004). These topics demonstrate an opportunity for physicians to discuss issues of STIs with their patients, filling the knowledge gap or correcting misperceptions resulting from peer communication. Between male and female college students, female college students were more comfortable communicating about sexual health topics with their peers (Rittenour & Booth-Butterfield, 2006). The least reported source for communication about sexual behavior was a physician (Pistella & Bonati, 1998).

College campuses. College students' significant lack of knowledge about STIs and risk behavior persists, despite the fact that in the college environment, safe sex resources such as condoms are often readily available. Substantial financial resources have been apportioned to the development of sexual health education programs. For example, in 2010, the Affordable Health Care Act pledged $375 million dollars in grants to fund sex and abstinence education (Redhead, 2015). Moreover, college students report being aware of the availability of condoms on college campuses (Eisenberg et al., 2012), and trust university-sponsored sexual health programming and staff more than information coming from peers and the internet (Eisenberg et al., 2012; Sprecher et al., 2008). However, most college students do not take advantage of these services (Barth et al., 2002). Instead, college students often opt to open up to peers and go online to talk about sexual topics instead of talking to a healthcare professional (Eisenberg et al., 2012; Sprecher et al., 2008). In general, these findings raise the question of how to educate college students about the risks of STIs and unplanned pregnancy and encourage the use of protective behaviors and safe sex resources.

Communicating with physicians. While college students have less contact with physicians than peers or parents (Sprecher et al., 2008), physicians still have a powerful opportunity to reduce emerging adults' sexual risk behavior through treatment and education about safer sex techniques. One study found a recent increase in college students' expectation to receive sex education from a healthcare professional (Sprecher et al., 2008). However, in order to receive the benefits of this communication, a patient must open a privacy boundary with a physician. When a physician is aware that a patient is sexually active, they are significantly more likely to discuss use of hormonal contraceptives, prophylactics, and risk for sexually transmitted infections (Kelts et al., 2001). Further, physician communication was found to play an important part in young women's selection of methods of hormonal contraception, and their ultimate use of that contraception (Harper et al., 2010). One study found that women who communicated with a healthcare worker were six times more likely to be currently using contraception (Huber & Ersek, 2009).

Other topics of discussion of sexual behavior between physicians and patients vary. One study found that reported topics included questions about the number of sex partners, contraceptive history, and STD history (Bull et al., 1999). Another study found that physicians self-reported topics from taking a sexual history, including safe sex (79%), the number of sexual partners (63%), and injection drug use (60%) (Temple-Smith, Mulvey, & Keogh, 1999).

However, physicians are generally reluctant to broach the subject of sexual health with their patients, and feel that they lack the skills to navigate this communication (Bull et al., 1999; Burd et al., 2006; Hinchliff et al., 2005). Physicians' reticence to talk about

sexual behavior has been found to be due in part to the lack of training, specifically regarding effective strategies to comfortably discuss sexual behavior (Bull et al., 1999; Burd, Nevadunsky, & Bachmann, 2006; Hinchliff, Gott, & Galena, 2005). Medical students often receive little or no training with regard to taking a sexual history (Coleman et al., 2013; Fuzzell et al., 2016; Tsimtsiou et al., 2006).

As previously stated, education concerning communicating about sexual behavior is required by the Liaison Committee on Medical Education (LCME), but the quantity and quality of training is unstandardized (Shindel & Parish, 2013). Much of the learning about human sexuality and taking a sexual history occurs in clerkship, and there are no standards for competency of taking a sexual history or discussing issues of sexual behavior (Coleman et al., 2013). In one study, approximately half of physicians reported insufficient training as a barrier to communication about sexual behavior with their patients (Henry-Reid et al., 2010). While medical students receive little or no training in taking a sexual history (Coleman et al., 2013; Coverdale et al., 2011; Fuzzell et al., 2016; Tsimtsiou et al., 2006), patients still presume that physicians will raise these issues (Alexander et al., 2014; Burstein et al., 2003; Epstein et al., 1998; Fuzzell et al., 2016; Metz & Seifert, 1990).

When physician-patient conversations about sexual behavior do occur, they often fall short. A significant body of research shows that physicians often find it difficult to foster an open privacy boundary about sexual topics. The findings from studies using diverse methods of assessing sexual communication show inconsistent quantity and quality of communication. Physician's self-reports of taking a sexual history every time they talk to a patient range from 88% (Burd et al., 2006) to approximately half (Bull et

al., 1999). In one study, among family medicine, and internal medicine, obstetrics/gynecology, and pediatric physicians, pediatric physicians were significantly more likely to take a sexual history (Wimberly et al., 2006). This higher rate of sexual history may be due to the fact that pediatricians often care for adolescents and young adults, the age group with the highest rates of STIs (Wimberly et al., 2006). Patient accounts of prevalence of physician communication about sexual behavior range from 15% (Schuster, Bell, Petersen, & Kanouse, 1996) to 30% (Rawitscher, Saitz, & Friedman, 1995). Third-party observations found that 65% of conversations included some content related to sexual behavior (Alexander et al., 2014). However, the average length of discussion was 36.5 seconds (Alexander et al., 2014). The same study surveyed patients about their conversations with the physician, and their perceptions of the communication was reported to be unsatisfactory in the areas of quantity of conversations, privacy and confidentiality, physician comfort with discussion of sexual behavior, language use, and definitions (Alexander et al., 2014). In semi-structured interviews with patients, many participants reported that physicians never broached the topic of sexual behavior during the interaction (Fuzzell et al., 2016). This gap between patient needs and communication comfort has persisted for decades (Epstein et al., 1998; Fuzzell et al., 2016; Lewis et al., 2011; Young, 1979). Physicians' comfort and competence with communication about sexual behavior may be influenced by patient's characteristics.

Gender and sexual orientation. Looking beyond general trends of the frequency and overall quality of discussions about sexual behavior, individual and communicative characteristics play a role in physician-patient communication as well. The gender of

both physicians and patients may influence communication comfort (Ackard & Neumark-Sztainer, 2001; Bilney & d'Ardenne, 2001; Burd et al., 2006; Mayer et al., 2008; Roter et al., 2002).

In an early exploration of the management of private information with physicians, college students were asked about whether they felt willing to disclose private sexual information to male and female physicians (Young, 1979). Individuals who responded to the study were more willing to disclose private information to physicians of their same sex (Young, 1979). This early investigation revealed that a physician's biological sex can have an impact on how patients manage private information about their sexual concerns. One study explored why college students avoided getting tested for STIs (Barth et al., 2002), and the women in the study cited physician gender as a reason for not seeking STI testing (i.e. preference for the same gender) (Barth et al., 2002).

Men and women have been found to have different preferences for physician-patient communication. An assessment of men's disclosure of private sexual information found that few (19%) men discussed their sexual concerns with their doctor, even though they did have sexual concerns (Metz & Seifert, 1990). When male patients did choose to reveal information, physician features of professionalism, empathy, trust, and comfort were primary for men to open up about their sexual practices (Metz & Seifert, 1990). In a comparison of gay and lesbian patients, gay men were more likely to have a male doctor, to be open about their sexuality, and to discuss sexual behavior (Klitzman & Greenberg, 2002). In another study, women respondents reported a desire for physicians to have the characteristics of warmth and empathy, and also wanted their physicians to protect confidentiality of their information (Metz & Seifert, 1988). A later study found that

female patients were twice as likely as male patients to spend more time talking about sexual behavior with their physician (Alexander et al., 2014). However, lesbian participants struggled to disclose their sexuality, in part because of a perceived barrier to finding a gay or lesbian healthcare provider (Klitzman & Greenberg, 2002).

These patients' concerns were corroborated by physicians' self-reported discomfort with communicating with LBGT patients (Khan et al., 2008). Physicians also reported trepidation in interviewing participants of the opposite sex (Burd et al., 2006). One study found that female general practitioners in particular were more uncomfortable with communication with the opposite sex (Temple-Smith et al., 1999). In another study, both male and female practitioners reported reluctance to communicate with members of the opposite sex (Burd et al., 2006). In addition to gender, communication factors effect physician-patient communication about sexual behavior.

Communication factors. Research shows that patients assess their physician's communication competence and strategies, and are more willing to communicate with physicians they perceive to be competent communicators (Baker & Watson, 2015). This willingness to communicate signals an open privacy boundary between physician and patient. Factors such as physician embarrassment, communication strategies, nonverbal behaviors, and implicit bias may influence perceptions of physician communicator competence, affecting a patients' willingness to communicate. This willingness to communicate can be framed by the boundary metaphor of the theory of Communication Privacy Management, or a willingness to open a privacy boundary (Petronio, 2002).

Embarrassment. In a healthcare setting, embarrassment is a major factor in physician reticence to communicate about sexual behavior (Verhoeven et al., 2003). This

reticence may encourage the patient to create a closed privacy boundary. Research using both physician self-reports and third-party observations provide evidence of embarrassment in taking a sexual history from patients (Epstein et al., 1998; Khan et al., 2008; Verhoeven et al., 2003). Observations of communication between physicians and patients found that the physicians in the study missed an opportunity to discuss sexual risk because of apparent emotional difficulties, such as exhibiting nonverbal embarrassment or nervousness (Epstein et al., 1998). A related factor influencing physician-patient communication about sexual behavior is the communication strategies physicians use to discuss patient sexual history.

Communication strategies. For physicians, some communication strategies are more likely to help a patient open a privacy boundary. One study analyzed this communication through a comprehensive conversation analysis, observing the ability of physicians to discuss sexual risk behavior (Epstein et al., 1998). Patients viewed a videotape of their communication with their physician. After observing the tape, the patient then described their experience of the discussion, and this data was coded for observable behaviors (e.g. ignoring patient's concerns), and interpretations of the discussion (e.g. patient perceptions about physician discomfort). The results revealed a variety of obstacles to communication about sexual behavior between physicians and patients. These obstacles create a closed privacy boundary between physician and patient. For example, the study found that in discussions with a patient, when physicians abruptly raised the issue without providing context, they were less likely to be able to continue the communication about sexual behavior (Epstein et al., 1998). Physicians were more successful in communicating about sexual behavior when they provided context for the

sexual health questions (e.g. “I ask all my patients about sexual behavior”) (Epstein et al., 1998). Some physicians also had difficulty continuing the conversation about sexual behavior, and prematurely changed the subject. For example, one patient described that her partner does not always use condoms, and the physician responded by asking questions about her use of cigarettes, and never addressed the sexual health risk (Epstein et al., 1998, p. 439). Her doctor asked, “Does he use condoms every time?” and the patient responded, “No, not every time.” The doctor said, “Not every time.” and the patient replied, “Uh huh.” After a moment of silence, the doctor said, “And you said you're a smoker.” Because of this avoidance, these physicians gathered less information about patient’s sexual health risk, perpetuating a closed privacy boundary. In this study, while some physicians were more successful compared to others in communicating with patients about sexual behavior, all observed patient encounters were found to have awkward moments and problematic language. For example, inappropriate humor, hesitations, and judgmental language were found throughout the physician-patient encounters. Nonverbal cues also limit physician-patient communication about sexual behavior.

Nonverbal behavior. Nonverbal behaviors are important for both disclosers and confidants to mark privacy boundaries (Petronio, 2002). Physician nonverbal behavior (e.g. turning their back to the patient, stuttering, or avoiding eye contact) is shown to have a significant impact on patient care. Nonverbal behavior is particularly important in privacy management because patients use nonverbal communication as a way to glean then the physician’s “real” feelings about the patient (Hall, Harrigan, & Rosenthal, 1995). This desire to discern the physician’s real feelings may be a result of the patient having a

sense of less power in the physician-patient interaction (Hall et al., 1995). With regard to patients' preferences for nonverbal communication, patients in one study favored physician nonverbal expressiveness, such as spending less time reading the medical chart, leaning forward, nodding, and using gestures (Hall et al., 1995). The importance of nonverbal communication is manifest in consequences for both the physician and the patient. One study found that observations of surgeons with a more dominant tone, and lower sense of concern in their voice were more likely to be sued for malpractice (Ambady et al., 2002).

In another research method of examining these issues, one study used standardized patients to assess how different physician nonverbal behavior impacted patient satisfaction (Griffith III et al., 2003). This study found that nonverbal behaviors such as smiling, eye contact, leaning forward, being expressive, and using hand gestures resulted in higher patient satisfaction (Griffith III et al., 2003). Nonverbal communication was found to be the most important factor in patient satisfaction when compared to verbal communication and the use of a checklist. Physicians may also be unaware that their nonverbal communication may convey a sense of negative judgment, create a closed privacy boundary for the patient. When describing barriers to communication with a physician, patients perceived their doctors' behavior to be rude, dismissive, and condescending, signaling negative judgment (Baker & Watson, 2015).

Implicit bias. Implicit bias may influence communication between healthcare providers and patients. Implicit biases are the unconscious, stereotype-based assumptions about patients which have the potential to affect physician behavior (Teal, Gill, Green, & Crandall, 2012). Implicit bias is distinct from conscious bias (Green et al., 2007), and is

often automatic (Teal et al., 2012). Physicians have been shown to hold implicit biases (White & Chanoff, 2011), particularly toward out-groups (Sabin & Greenwald, 2012; Van Ryn & Fu, 2003). These biases have the potential to exacerbate systemic healthcare inequalities (Sabin & Greenwald, 2012; Van Ryn & Fu, 2003). Research suggests that implicit biases can also affect physician-patient communication (Hagiwara et al., 2013). In one study, physicians took an Implicit Association Test to assess implicit biases against Black patients (Hagiwara et al., 2013). In third-party observations of communication with Black patients, physicians with implicit biases (but not explicit biases) toward Black patients were shown to exhibit verbal dominance, less positive emotion and lower patient-centeredness (Hagiwara et al., 2013).

In an exploration of communication about sexual behavior, approximately two-thirds of all physicians surveyed reported reluctance to care for patients who injected drugs, were sex workers, or were gay or lesbian (Khan et al., 2008). Physician implicit bias has also been found to impact patient care along the lines of race, gender, age, and sexual orientation (Van Ryn & Fu, 2003). These patients likely need the services of physicians the most, and yet, they are less likely to receive the care they need (Burd et al., 2006; Fuzzell et al., 2016; Khan et al., 2008).

A healthcare provider's evaluation of certain patient characteristics can serve as criteria for whether or not they will broach the subject of sexual history, encouraging a patient to open a privacy boundary. Further, a patient's perception that their physician was reluctant to care for them due to implicit biases would likely create a closed patient boundary. However, some might argue that while physicians may hold implicit biases against patients, patients may actually be unaware of these biases. What is unclear from

these studies is how and whether patients experience these communication biases, and how that experience influences future communication with physicians. A new research paradigm has emerged that shifts the emphasis from physician-centered communication to focus on patients' experiences of communication with physicians.

Communication context and the patient's perspective. In the recent past, the dominant biomedical approach situated the physician-patient communication as a hypothesis-driven set of yes- and no- questions, rendering the patient secondary to the encounter, and emphasizing the goal of the communication that is "objective" and scientific (Hughes, Bamford, & May, 2008). This paradigm of research has viewed private information as a unidirectional, discrete transmission, in contrast to a privacy management approach (Bute, Petronio, & Torke, 2015; Petronio & Kovach, 1997; Petronio & Sargent, 2011). However, recent research on physician-patient communication has integrated socio-cultural perspectives on the physician-patient encounter. As a result, there has been a wide-ranging call for a new emphasis on humanistic and values-based medicine for the benefit of caregivers, patients, and families (Bleakley, 2015; Little, 2002; Markakis, Beckman, Suchman, & Frankel, 2000; Souba & Day, 2006).

One example of this new emphasis is Street's ecological model of medical encounters (Street, 2003). This model positions the physician-patient interaction at the center of the model, and describes the potential influences from media influences, organizations, culture, and political and legal contexts (Street, 2003). Each of these factors have the potential to shape medical interactions, and encourages researchers to account for these various social factors when investigating physician patient interaction

(Street, 2003). In addition, other research in this area shifts focus away from a frame positioning the physician as the dominant person in the encounter, who drives the interaction and engages in transactional communication with the patient until the interaction is completed (Epstein & Street, 2011). Instead, a large body of research in this area now integrates the subjective perspectives of patients and acknowledges the importance of both the physician and the patient in the interaction (Hughes et al., 2008). This new paradigm of research, termed patient-centered care, not only provides an alternative lens for understanding the physician-patient relationship, but also inherently highlights the importance of communication. This emphasis creates new opportunities for health communication researchers to engage in applied communication research in medicine, and in particular, account for the discloser and the confidant in privacy management.

The 2001 Institute of Medicine (IOM) report (Briere, 2001) defined patient-centered-care (PCC) as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." In the research that followed, the construct has been variously defined as a style of communication, a philosophy of medicine, respect for values, a type of therapeutic relationships, and a quality care indicator, among other definitions (Roter & Hall, 2011). PCC has been adopted widely in research exploring physician-patient communication (Hughes et al., 2008). A 2008 review of literature applying PCC found a total number of 985 patient-centered publications (Hughes et al., 2008). Patient-centered care is an important movement in research on physician-patient communication because it highlights role of the patient in the physician-patient relationship, and attempts to

capture the "human" factors of communication in the encounter. In fact, communication has been emphasized as the "core" of patient-centered care (Stewart et al., 2000).

Research has sought to define the functions of PCC and explain the related PCC communication skills. The proposed functions of PCC communication are: fostering healing relationships, exchanging information, responding to patients' emotions, engaging in informed and collaborative decision making, and enabling patient self-management (Epstein & Street, 2007). There is a set of communication skills associated with each of these functions. These interrelated skills involve genuinely engaging with the patient to learn about the patient's concerns and values, as well as listening carefully and interpreting the answers (Larson & Yao, 2005). The importance of genuine emotional connection and empathy for patients' experiences is also emphasized, as well as performing the appropriate communication skills (Larson & Yao, 2005). Other proposed communicative PCC patterns included a longer interaction, use of humor, orientation statements, soliciting patient's opinions, encouraging patient input, and gauging patient understanding (Levinson, Lesser, & Epstein, 2010). Nonverbal markers of patient-centered communication include facial expressions, hand gestures, body posture, and paralinguistic factors such as interruptions, paraphrasing, loudness, and pitch (Roter & Hall, 2011).

The operationalization and measurement of PCC in interactions has changed over time (Epstein & Street, 2011). Initial efforts to operationalize and measure patient-centered communication focused on whether the patient was able to ask questions in the encounter. Other attempts at measurement have asserted that the ability to ask a question is not sufficient to qualify as active participation, and instead, physician communication

should encourage each patient to participate and fully engage in the conversation (Epstein & Street, 2011). While researchers often used methods such as observations of physician-patient communication, third-party assessments of patient-centeredness (such as audiotapes and analysis by researchers) may not correlate with care outcomes (Bechtel & Ness, 2010). However, *patient's perceptions* of patient-centered care were in fact associated with outcomes (Bechtel & Ness, 2010). These findings suggest that the most useful construct of "patient-centeredness" treats individual patients as the authority on patient-centeredness (Bechtel & Ness, 2010). From the perspective of the patient, certain subjective factors contribute to patient-centered care (Bechtel & Ness, 2010). These factors include treating the "whole person," meaning that instead of treating a particular body part or disease in isolation, a physician considers the social environment in order to recommend treatment which can be integrated into their lifestyle (Bechtel & Ness, 2010). It was posited that these considerations would also help to prevent misdiagnosis and drug interactions, as well as improve patient adherence to treatment (Bechtel & Ness, 2010). This recent focus on the needs and perspective of the patient, in combination with a population-specific risk behavior create the opportunity for nuanced understanding of communication in this space. Qualitative research exploring patients' perceptions of physician-patient communication about sexual health using CPM as a guiding lens can provide a complex understanding of these issues.

Research questions. In light of the significant problem of female college students' risky sexual behavior, the dissertation seeks to better understand the gap in physician-patient communication about sexual behavior. Guided by the results of the pilot study and the theory of CPM, this study will address female college student's

communication with physicians about sexual behavior via the following research questions:

R1: How do female college students decide to whom, where, and how much private information is shared with healthcare professionals about sexual behaviors?

R2: What are the privacy rules female college students use when managing private information about sexual behavior with healthcare professionals?

Chapter 3: Methods

This chapter first describes a pilot study used to collect preliminary data and assess the feasibility of the dissertation study. Then, the dissertation study procedures are outlined. These procedures include recruitment strategy, the participant demographics, interview procedures, and analysis.

Pilot Study

This pilot was conducted to evaluate the viability of the study, and learn about the issues and concerns of the participants regarding physician-patient communication about sexual behavior and tailor the interview questions. Prior to the pilot study, an earlier study using interviews and focus groups provided some insights as to the extent to which college students had experiences communicating with healthcare professionals and were willing to talk about them (Hernandez, 2018b). While this earlier study focused specifically on peer communication about condoms, some of the results revealed college students' willingness to share their perceptions about communication with healthcare providers. The results of this earlier study also informed the questions for the dissertation pilot study survey, contributing natural, informal language for the survey questions. The dissertation pilot study survey questions gathered demographic information, as well as information about openness of communication with physicians regarding sexual behavior.

For the dissertation pilot study, after achieving Institutional Review Board (IRB) approval, college students were recruited via undergraduate Communication Studies courses to participate in a brief survey containing closed- and open- ended questions about how college students perceived their interactions with healthcare professionals.

College students were informed of the topic of interest at the beginning of the survey and were told they were able to skip or leave any part of the survey if they wished.

Pilot study results. In total, 19 participants completed the online pilot study survey. Eight participants identified as male, and eleven participants identified as female. The average age of participant was 19, and all of the participants were freshmen in college. With regard to race, participants identified as Asian (one), Black (one), Latino (one), White (twelve), Other (Biracial- four). Four participants identified as being in a serious relationship, four reported being in a casual relationship, and eleven reported no relationship.

Sources of communication about sexual behavior. When recalling their experiences with healthcare facilities, participants reported going to a: clinic (two), private practice (three), hospital (two), not sure (five), and other (six). Of the participants who reported other sources of communication about sexual behavior, open-ended question responses varied from "nowhere," "friends or online," and "parents." Participants' knowledge of the types of healthcare providers also varied and responses revealed that some participants were unsure of the differences between a physician, nurse practitioner, and nurse. Several respondents reported being "not sure" of what kind of healthcare professional they spoke to, and some selected the option of "other," and wrote in the term "doctor." Of those participants who did report speaking to a specific healthcare professional, eleven reported speaking specifically to a physician. Overall, three participants reported not talking to healthcare professional about sexual behavior at all.

Topics of communication. Participants identified several different topics of physician-patient communication about sexual behavior, including using protection during sexual activity, birth control, and the best practices of maintaining sexual health. One participant recalled the superficial yet persistent questioning of one physician, stating, "It never got too deep. [I was just asked] the recurring question, 'Are you using protection?'" Another participant described the strictly utilitarian nature of communication with the physician,

> The only sexual behavior I've talked about with my physician is if I had sex or if I was pregnant, because then I wouldn't be able to get my birth control. I got my birth control since I haven't had sex and I wasn't pregnant. We also talked about when women have to get that test at 21 for their lady parts.

This participant was referring to the recommendation from American Congress of Obstetricians and Gynecologists (ACOG) to undergo a pelvic exam at the age of 21. It is important to note that ACOG guidelines also recommend a "first visit to the obstetrician–gynecologist for screening and the provision of preventive services and guidance take place between the ages of 13 years and 15 years," and regular pelvic exams for women younger than 21 when necessitated by medical history (American College of Obstetricians and Gynecologists, 2018).

Communication with parents and friends. The pilot study survey asked participants to compare comfort of communication about sexual behavior with parents, friends, and physicians. These pilot study results help contextualize the role of communication with physicians for these college students in comparison to communication with parents and friends. Findings were mixed regarding the extent to which participants felt comfortable discussing sexual topics with their parents. Some

participants preferred speaking with parents instead of physicians, while conversely, other participants preferred speaking with physicians rather than parents. One participant clarified their perception of the difference between communicating with parents and physicians, stating, “My parents are more concerned with the morality behind sex, while my physician's primary concern is my well-being.” This response spoke to implicit concerns about negative judgment of sexual behavior.

When comparing parents and physicians, some participants reported that both shared qualities that facilitated open privacy boundaries. Several participants stated that parents and physicians “both just want what is best for you,” and another said “[parents and physicians] are just trying to protect me and they're giving me information that I'll need to know for the future.” Another participant said, “My parents are extremely open about sex and sexual health. My [healthcare] provider does not appear judgmental, much like my parent.”

Regarding communication with friends, one participant remarked that perceptions about avoiding negative judgment encouraged open communication with peers, “I can tell my friends anything because they won't judge me.” Another participant referenced age and similarity of experiences as a criterion for communication with friends about sexual behavior, “My friends are my age and they know a lot of similar things as me in regards to sexual trends, while my healthcare professionals are usually older than me.” For this participant, the communicator similarity of peers served as a criterion for privacy management.

When comparing friends and physicians, one participant said “Depending on the friend, we are extremely open about sexual health. I give out condoms to them, actually.

Nothing is weird with them, much like to a doctor." These participants valued the ability of parents and physicians to appear open and judgmental.

Physicians' characteristics and communication. Participants in the pilot study reported that certain characteristics of healthcare providers encouraged open privacy boundaries. These characteristics included communication strategies (e.g. not interrupting, open body language, and less judgmental), and personality characteristics (e.g. openness, friendliness, kindness, humor and caring). Physician demographics may also play a role in college students opening a privacy boundary about sexual behavior. One participant also described the importance of physician similarity for communication comfort, citing the importance of a provider "being a woman, my age and of a similar background." Another participant wrote, "Older, white men make me anxious inherently." These statements illustrate that physician characteristics like communication style and physician demographics are important when college students decide to open a privacy boundary.

Other communication factors fostered closed a privacy boundary with a physician, such as a lack of confidentiality, and perceived physician judgment. For example, one participant expressed concerns about opening up about sexual behavior "if they're going to tell my parents what I've said." Another participant described fears of a physician delegitimizing their concerns, or "being cut off, invalidated." When asked if they actually told a provider about their perceptions of a lack of confidentiality and judgmental communication, most participants reported not speaking directly to the provider about their concerns.

Perceptions about limited time to communicate also played a factor in how participants decided to open up about their sexual behavior. The need for brevity was described as an important rule for this communication; one participant stated, “basically, if it seems clear and concise, I share. They're busy people.” Seriousness of topic also was cited as a criterion for communication; one participant said, “I determine whether or not it is serious enough [to share],” and another questioned, “Will I die if I don't say this?” These findings echo previous findings about the importance of the experience of urgency and time in revealing private information about taboo topics (Ebersole & Hernandez, 2016).

The results of this pilot study illustrate that college students have experience with developing privacy rules with physicians, and that certain criteria may be used to make decisions about privacy rules. These criteria could include communicative and demographic factors (such as physician non-verbal behavior, and physician gender), as well as a sense of urgency about a particular health issue. Respondents also described perceptions about time limitations in communication with physicians, the requirements for annual gynecological exams, and the need to obtain prescriptions for birth control. However, college students may not be familiar with the titles of healthcare professionals, such as primary care physician, general practitioner, and nurse practitioner, or may not recall whether they visited a clinic or hospital. In addition to confirming the fact that college students have experience with developing privacy rules with physicians, this pilot study served as formative research to tailor a semi-structured interview protocol for the dissertation study. As a result of this pilot study, the interview guide (Appendix A)

included questions about communication strategies, perceived judgment from physicians, and time limitations.

Dissertation Study

Data collection. Qualitative methods have the potential to uncover the complexities of female college students' privacy management about sexual behavior. Extant research studies exploring sexual health communication between patients and physicians have used methods including secondary analysis of national survey data, review of audio and videotapes of actual patient encounters, and survey questionnaires (Alexander et al., 2014; Burstein et al., 2003; Epstein et al., 1998; Fuzzell et al., 2016; Lewis et al., 2011; Metz & Seifert, 1990). Building on this literature, semi-structured interviews exploring why and how female college students decide to open a privacy boundary with a physician can give insights into the subjective perspective of the patient, and provide deeper, nuanced understanding of this communication.

The interview format holds several advantages for this study. First, interviews encourage participants to share their experiences and opinions regarding privacy management of sensitive topics, and provides a more private and confidential space than the use of focus groups (Tracy, 2012). Further, interpretive analysis of these interviews can build theoretical links that otherwise might not have emerged through analysis of surveys or highly structured interviews (Tracy, 2012). Finally, privileging the perspective of the patient avoids the assumption that it is the physician who has total control over this communication. Instead, this approach gives the patient the opportunity to articulate their experiences in their own words.

In this study, a semi-structured interview guide was used to gain understanding of the specific privacy rules and the criteria used for privacy rule development. The interview guide (Appendix A) contained high-priority questions, delineated in bold, and probing questions highlighted in grey text to guide the interview process, and allowed the interviewer to prioritize the interview questions given time constraints and the flow of discussion.

Recruitment. Selection of participants was purposive; only female college students were included in the study. The selection of this population is guided by both the sexual risk behavior and communication practices of the participants. As illustrated in the literature review, female college students, in particular, are at risk for the negative consequences of risky sexual behavior. Further, research indicates that women's experiences with physician-patient communication about sexual behavior differ in important ways from men. Thus, this study recruited female college students to participated in this study.

After the study received IRB approval, participants were recruited via both Communication Studies and Health, Physical Education, and Recreation undergraduate courses at an urban, mid-western university. Participants were informed of the study via an emailed flyer and offered extra credit in their courses for participation. Students who could not or chose to not participate in the study were given an alternative assignment to receive extra credit. Participants who were interested in participating in the study completed an online form where they entered their email address, first name, and preferences for the time and date to schedule an interview.

Participant demographics. Twenty interviews were conducted in a private space on the campus of an urban mid-western university. Interviews ranged from 23 minutes to 1 hour 20 minutes with an average time of 45 minutes. All of the participants identified as female, with an average age of 20 years old. Participants identified as White (12), Black or African American (four), Hispanic or Latino (three), and Asian (one). Regarding university class standing, students were freshmen (seven), sophomores (seven), juniors (three), and seniors (three). Ten participants were in a serious relationship, seven were in no relationship, two were in casual relationships, and one responded "other." Seventeen participants identified as heterosexual, two identified as bisexual, and one identified as "other." Ten participants identified as religious, and of those ten, seven identified as Christian, two identified as Catholic, and one identified as Lutheran. Regarding participant experiences with physicians, all of the participants responded to the questions and told stories specifically about their experiences with doctors.

Interview procedures. On the day of the interview, participants received a combined information sheet and implied consent form. To ensure participant confidentiality, the participants were not required to sign the sheet and consequently reveal their name and association with the study. To begin the interview, the researcher read through the first paragraph of the interview guide, and then gave the participant the opportunity to ask any questions about the study or interview process. The opening statement read as follows:

> You are here to participate in a research project studying college students' perceptions of how they talk about sexual behavior with their healthcare provider. You will not be asked to specifically talk about your sexual behaviors. There is no right or wrong answer to these questions; I want to learn more about what you think about communication about sexual behavior. The names of the people who participate, and organizational

> names and other identifying information will not appear in any transcriptions or reports resulting from this research. If I ask any question that makes you uncomfortable, you don't have to answer, and you may leave at any time. What questions do you have for me about the process? I'm going to be using fake names when I write up these data. I can make one up – or is there a name that especially suits you?

The interview questions were created and prioritized according to the tenets of CPM and the research questions. The questions in the interview guide were designed to probe the development of privacy rule criteria, as well as specific privacy rules. The interview protocol contained questions asking the participants to recall their communication with healthcare professionals, and then reflect on a specific encounter with a healthcare professional. This reference to a specific healthcare visit was designed to enhance the participant's memory of the encounter and allow them to recall the specific details of the communication. Probing questions about perceived judgment, urgency, and physician bias were derived from the pilot study, and extend the researcher's previous work exploring college student privacy management about sexual behavior with peers (Hernandez, 2018b), and implicit physician bias (Hernandez, 2018a; Hernandez et al., 2013). The researcher was mindful in the interviews to use skillful listening practices such as comfort with silence, and facilitation skills like paraphrasing and orienting the conversation (Whaley, 2014).

Analysis. The analysis consisted of interpretation of notes taken during the interview process, memos of the researcher's reactions, and the recorded audio and transcribed responses of the participants. The author then transcribed the interviews with the assistance of a transcription software. The researcher then refined the memos to include reflections gained during the transcription process. After each interview, the author also made a note of her perceptions of theoretical saturation (Tracy, 2012). The

researcher assessed saturation by recording her perceptions of the extent to which new information was gleaned from the data.

Because of the importance of privacy in communication about sexual behavior, the findings of this study were interpreted through the lens of Communication Privacy Management theory, weaving the research findings with the tenets of the theory of CPM. For the transcription and analysis, participants were given a pseudonym to protect their privacy. Simultaneously during the writing and refinement of the memos and the initial transcription, the researcher confirmed the presence of descriptions of privacy management present in the data. Then, using the software Dedoose, the data was analyzed line-by-line (Tracy, 2012). While Dedoose has many capabilities including quantitative analysis and data visualization, for this project, Dedoose was only used to organize, segment, and categorize the data (Kaefer, Roper, & Sinha, 2015). Primary- and secondary- cycle coding were used to first categorize patterns in data, and then develop an explanation about the relationship between these categories (Tracy, 2012). The researcher then began primary cycle coding. In primary-cycle coding, the researcher defined broad categories of participant's responses, using words and short phrases to describe participant's statements about patient-provider communication about sexual healthcare topics, such as "having empathy for the physician" and "worrying about judgment." A simple codebook emerged from this analysis, describing broad categories of research findings.

Then, using secondary coding, a typology was created to explain how these categories and sub-categories related to each other, creating an organized explanation of the patterns of privacy management about sexual topics (Tracy, 2012). Throughout the

coding, the author took an iterative approach to analysis, alternating between the emerging context-specific results, and the concepts of the theory of CPM. The author also employed the constant comparative process (Tracy, 2012), comparing the themes to the data, and revising the codes to represent new findings the data. The author made use of analytic memos, proposing theoretical relationships between themes in the typology. This approach resulted a parsimonious explanation of privacy rules and criteria for college students' discussion of sexual behavior.

Chapter 4: Results

Discussions of privacy were woven throughout each of the interviews. At times, the interviews were light-hearted, and at times, intense. The participants' responses provided deep insights into female college students' privacy management about sexual behavior. The results are organized by primary themes and guided by the theory of CPM. The first primary theme reveals college students' privacy rules and outlines the seven criteria participants use to develop these privacy rules. These criteria include societal, cultural, and gender-based rules, the benefits and risks of disclosure, physician's communication competence, power, and a sense of limited time. The second primary theme explains overarching dialectical tensions that drive privacy management decision-making, including openness/closedness, conventionality/uniqueness, and emotions/objectivity.

Privacy Rules

Participants described how they decided to open up to healthcare professionals about sexual behavior using privacy rules. The following primary theme provides an analysis of how different factors shaped participants' privacy rules for communication with physicians. Privacy rules discussed in the interviews varied in scope from stable societal and cultural privacy rules to more malleable privacy rules triggered by the catalyst criteria of motivational, gender, and risk-benefit rule criteria. These different factors illustrate the dynamic interaction between social systems and interpersonal communication, showing how different levels of communication come to bear on interactions with a physician.

Societal privacy rules. An individual's decisions whether to open or close a privacy boundary are often driven by socialization throughout the lifespan. In the current study, participants explained that as a result of societal expectations, people generally do not open up about sexual topics. Generally, societal research refers to investigations in a territory which may contain a multitude of different cultures and nationalities, but share forms of socialization such as education and other systems (Rokkan, 1993).

Discussed in an article by Bute, Brann, and Hernandez (2017), a societal criterion for privacy management involves the processes by which individuals learn and internalize societal expectations regarding privacy management about certain topics. This criterion was initially explored in their communication about miscarriage, and the rules were defined as collective, pre-existing and routinized rules for privacy management. Participants in Bute, Brann, and Hernandez (2017) revealed that there is a societal expectation in the United States that topics surrounding miscarriage are taboo. In the current study, participants defined sexual topics as being similarly taboo. In a similar way to the study by Bute, Brann, and Hernandez (2017), participants used the word society to describe these rules, and spoke about this aspect of socialization in different ways than cultural privacy rules. Participants in this study often spoke about the socialization processes (i.e. the education system) that shape expectations about privacy management about sexual behavior.

In the present study, participants explained that broad societal expectations regarding communication about sex influenced individual's comfort with communicating about sexual behavior with their physician. Statements about societal expectations differed in important ways from discussions of culture. Similar to discussions of cultural

communication in Petronio (2002), discussions of culture among participants often involved cross-cultural communication (e.g. communication as a Middle Eastern woman with a physician from the United States). In contrast, societal privacy rules referred to the implicit, understood, socialized privacy rules about sexual behavior. Miranda spoke about how the ongoing processes of socialization creates a cone of silence around topics related to sexual behavior,

> You're not supposed to know yourself … experiencing your own body [in a sexual way] is frowned upon, and then that makes mothers and fathers who feel that way, and that turns them into parents that feel that way. And then they teach their kids that. I feel like my mom did a good job [but] it almost makes me sad like that people are so scared to talk about it, but I also understand, cause I'm scared to talk about it…

Miranda was acutely aware of the fact that society influences how parents teach their children which topics are private, creating a cycle of reticence to communicate about sexual behavior. Miranda later described how the societally-driven emotion of fear created a closed privacy boundary,

> That's the hardest thing is like girls, especially young girls… I was so mortified to go to the doctor. Even saying "vagina" made me so anxious. Just because, that's what you see on TV, that's what the school's telling you, that's what my middle school health class… I didn't know… a friend of mine who didn't even know she had two holes until she was nineteen. That baffles me… but I can't blame her… and I feel like you shouldn't be embarrassed to learn about your own parts.

Miranda explained how this process of socialization, and in particular, taboo regarding the language about sexual behavior, occurs via various channels such as the education system and media messages.

Lucy also emphasized the importance of systematic education about sexual behavior, and spoke about her beliefs that education in this area currently falls short, and with significant consequences,

> I feel like high schools need more [education about what] your body's going to turn into, and what your options are. And besides just abstinence… and I really, I feel very strongly that education is like a key for people's sexuality and what is going on inside of you… so, because I know my cousin in [Large Midwestern city] she said that they are- I don't know this is like a statewide or not- but she said they're not allowed, schools are not allowed to have any sort of like puberty education, or sex education whatsoever. And I feel like she has been through a lot of stuff at a really young age, that is, very sexual things when she was like twelve that aren't … I feel like if everyone was educated a little more, people would know [more].

As Lucy described, education is one important aspect of socialization, and reflects the values of society, contributing to the silence surrounding sexual behavior. When the education system ignores discussion of sexual activity, this omission has not only consequences for the knowledge of students, but also implicitly communicates that discussion of sexual behavior is not the norm.

Ferni described a general societal rule about discussing sexual behavior, and how physicians are not immune to following this rule. She said,

> You don't really have a conversation about [sexual behavior] with random people in the street, so talking about it in a room with one other person, you know, it's even more awkward. Doesn't matter that they're a doctor. Also the doctor could be thinking like, "Oh, why?" [are they broaching this topic]… I used to be really, really, really shy about talking about anything with the doctor, and then you see the importance of how bad some of these thing can be, and that you should really, really communicate, it's making me talk more to my peers about it, talk my family about it, talk to doctors about it, so it's really, really beneficial. So, I feel like, that's just me. But like, with everybody else ....

Ferni explained that she was going through the process of breaking down her boundaries surrounding information about sexual behavior, and that society may be behind with this communication.

Some participants were particularly aware of how societal expectations shape their beliefs about sexual behavior. For example, Layla described her perspective on STIs,

> I really think [communication] should not be focused on sex and the consequences as punishment. That makes such a negative stigma for so many people. And also, using STDs as a fear tactic… I have such a bias towards people with STDs. I just do, and I know it's because of that, because "it's dirty" and all that stuff. And I have to do that whole thing like "Your first thought is the thing you were conditioned to believe, but your second thought was the one that you're training yourself." I had a friend who thought that they had an STD and I had to literally push down that thought. I am very aware of my bias towards it, and I try not to be… because it's like any other disease.

Layla explained how she has been "conditioned" to internalize the taboo of sexual health. She later went on to explain how this taboo can contribute to silence surrounding sexual health,

> To me, I feel like a lot of people just don't know about [sexual health] because it's just not something that's talked about…The only time STDs are talked about is to villainize them and to make them dirty and disgusting. That's the thing. Diseases correlated with genitals really have a high probability of not being talked about. I think that's a reason why a lot of people just don't know about it.

Throughout the interviews societal expectations were woven into discussion of communication about sexual behavior. In addition to societal rules, participants discussed more specific cultural rules, and how those rules guided their privacy decision-making.

Cultural privacy rules. In addition to the broader societal expectations about privacy management of sexual topics, participants in this study described how their specific cultural experiences shaped their privacy rule decision-making. Participants described how their experiences in a cultural group with shared history, values, and language added a layer of understanding about privacy rules, and at times created

tensions in decision-making about privacy management about sexual behavior. For example, cultural mores such as strict prohibition of unmarried pregnancy can guide patient privacy boundaries.

Thabisa described how her family immigrated to the United States from a suburb of a city in East Africa, and she explained that her family sought out a physician from the same area. She explained,

> I've been to different kinds of doctors. This one doctor that my mom found [from our area of Africa] has specific kinds of values. And so, when I went to him for a problem, they had to do a urinalysis. And he was like, "Well I'm not going to test you for pregnancy because I know that's not possible." And I was just like, "Well you know, it could be." But I couldn't say it because my mom trusts him. So, things like that, small comments that some doctors make.

As first-generation American, Thabisa finds herself negotiating communicating about sexual behavior within expectations of her mother and doctor who share her culture, while also knowing that her sexual behavior may not conform to those expectations.

In another case, Katie came from a Middle Eastern country, and described how her culture prevented communication about sexual behavior. She explained,

> My mom, she's so traditional, so it would be just so weird that I'm going to ask any question from her. You know, the American family, they are completely different . . . they are not so traditional compared to the Middle East people.

Another participant, Alina, was adopted from Eurasia and came to the United States as a teenager. She described how coming from a different culture made it hard for her to know to whom to trust,

> I didn't know, for me in the beginning since I wasn't really from here … I did not know enough English. I didn't even know how to communicate that stuff to new parents or new doctors.

Alina attributed this language and cultural barrier to her lack of awareness and access to resources to prevent the negative consequences of sexual behavior. These barriers also created discomfort with communicating with physicians and a fear that she would be judged. Eventually, Alina would describe how these barriers contributed to her experiencing an unplanned teenage pregnancy. In addition to cultural privacy rules, some of the women discussed gender-based privacy rules, particularly how physician gender can influence privacy rule decision-making.

Physician gender. Some participants stated that physician gender served as a criterion for privacy rules. Most participants who referenced gender stated that they were more comfortable opening up to a physician who was female. There were varying reasons given for why physician gender was important. Lucy described how physician gender allowed her to open up after being raped,

> My relationship with this OBGYN, it was actually, it was at a child advocacy center that she became my OBGYN because I was raped, and so she already knew that whole situation. So, it was just like comfortable for me to go in… and her, and her nurse who was with her, they were like the only two in that whole center that actually seemed to like give a shit about what I was, what was going on. So, they were also like the only two females who were involved in the whole situation which also made me feel more comfortable to be around them.

Of the social worker, police, and healthcare professionals, her physician and nurse were the only two women who helped Lucy after she had been raped. For Lucy, it was implicit that their gender made her feel more comfortable communicating with them. Later in the interview, Lucy said that she continued to receive healthcare from this particular physician.

Other participants were more direct about why physician gender was important for developing privacy rules. Miranda explained in detail why she preferred talking to a female physician,

> It's easier for me with a female doctor, because it's like she's got the same kind of stuff, she knows how it works, she knows what's going on with it… and I feel like you know, even though men still study and they still do all that, but they don't have it, they don't feel it every day, know what it feels like when this hurts… just so you know I'm not trying to be like "men are trash…"

In this quotation, Miranda emphasized the logic behind her preferring to speak with a woman, and how a female physician's embodied experience of being a woman was an important source of knowledge in patient care.

Julie spoke about her past experiences seeking from male doctors, and how she believed that the communication style of her female physician was more effective,

> I might be more comfortable with a woman doctor. Yeah, but I mean, out of all my experiences, I've probably had more positive ones with women, and it might have just been that… she actually seemed to care more, honestly. I feel like she had me open up a lot more than what I had to the past two doctors. Because I just thought it was hopeless at that point, but I went anyways, [because] I was trying to get something to like help the pain. And she actually was the most helpful, she prescribed medication that actually helped, because I felt like I could talk to her more.

Julie's reasoning for preferring a female physician was based on her experiences with only three physicians, however, these experiences may be generalized; some research has found an association between physician gender and empathic concern (Gleichgerrcht & Decety, 2013). Julie went on to explain how the visible discomfort of the male doctor when touching her made her feel uncomfortable as well,

> I would say some at least of the male doctors that I've interacted with they almost feel like they can't touch me- and I get they're trying to be respectful, not just, you know, go for it- but it's like they're making me feel almost uncomfortable with how uncomfortable they are. It's like "Oh, well

> maybe I shouldn't be ok with you feeling my back for the heartbeat or whatever. It's like it makes a very tense situation, and I don't feel like opening up in a tense situation.

Julie described how her male doctors' discomfort caused her to shut down, and this discomfort with communication fomented an impermeable privacy boundary. When making privacy decisions, participants also described how they drew from beliefs about the potential risks and benefits of disclosure.

The benefits and risks of disclosure. Participants described how perceived benefits and risks of disclosure served as catalyst criteria for privacy management about sexual behavior. Specifically, they explained how linking a physician into a privacy boundary held the specific benefit of being able to make decisions with their doctors. They also explained that this disclosure was a necessary condition of receiving health care from their doctors. Further, while private disclosures generally hold inherent risks (e.g. having private information disclosed to unauthorized third parties), for these participants, risks of communication with doctors were seen as severe enough to warrant a closed privacy boundary. The five potential risks of opening a privacy boundary included anticipating physician bias and judgment, fears of delegitimization, physician discomfort, and breaches of confidentiality.

Decision-making with doctors. Participants described one potential benefit to open up to their doctors about their sexual behavior: the opportunity to make decisions with their doctors. Ferni explained how a patient might be motivated to open up to a doctor in order to engage in shared decision-making about birth control. She noted, "[There are] different kinds of contraception and different ways to use them, so [I'd talk to a doctor about] what's best for me." For some patients like Ferni, making a decision

about their health is complex and involves the physician's deep understanding of the patient's social history as well as medical history. For example, Ferni later went on to describe a positive experience with decision-making with doctors, saying,

> I feel like I've had a conversation [with my doctor] where like, I can kind of talk about, like, the stuff in my life. And they helped with that. So, like with birth control, my aunt, was diagnosed with breast cancer. So, the birth control that I was on, [my mom] was worried that it would make it so that I could I would be likely to develop that kind of breast cancer that my aunt had. So, [my doctor] was thinking about, like, you know, the different kinds of birth control. She seemed so concerned… she was really, really helping me out. And I was like, "everything is going well," but my mom's concerned because my aunt had breast cancer, so I don't know how that popped up, but we talked about that. And I was really good about that because she [said], "If you're really worried about that, we should probably get you on a different one."

In Ferni's case, her doctor understood her fear that birth control may heighten her risk for a certain type of cancer and helped her find an alternative birth control. This perceived benefit of addressing her fears about birth control caused Ferni to link her physician into her privacy boundary.

Another participant, Mary, also valued the opportunity to make decisions about her health with her doctor,

> Asking for a [doctor's] opinions, giving [patients] all those options, and explaining them, and doing all that over again would just be the best thing. If the person is still unsure, starting them out with the easiest option, having them go for six months or so and then saying "Come back. Let's see how you're doing. If you're not liking it, then we'll switch to another thing." I want them to actually give me the options that they actually feel are going to work…If you were to do birth control, they say "This is the pill, this is how it is. Then there's your shot." Then the doctor is like, "Well, I personally have the preference of the shot, or the IUD, or this, and that." I like that they tell me "this is my preference," and they tell me why, but they don't shove it on me. The fact that I would choose the pill over the shot would be . . . They're like, "Okay. I understand why you don't want to come in [for the shot]. You want to control that you take this once daily. You don't want to have to come in every three months and blah,

> blah, blah, blah." So, I think them giving their opinions is nice. Just don't be trying to shove it down my throat of "It's this way or no way."

Mary's description highlights how shared decision-making works between physicians and patients- the patient discloses their preferences, the physician outlines their perspective, and then they engage in an ongoing communication about the treatment. By describing this process, Mary emphasized that she wanted to have the opportunity to have *shared* decision-making with her doctor, but didn't want her doctor to force their opinions on her.

Olivia also used the example of deciding about which birth control to choose to exemplify the importance of decision-making with doctors. When asked about the topics she ask her physician about, Olivia said,

> Definitely talking about different kinds of birth controls [is important], because I know for me, there's so many [options]… either you could get like a shot, but there's a lot of side effects with shot or a pill. Your doctor is finding the most effective birth control for who they're working with. Because there's a lot of girls who forget [to take birth control] or there's a lot of girls who just can't deal with the shot because it's too much of an emotional stress. So, just talking about birth control, like birth control options, I think would be very beneficial because [otherwise] they're just like "here's some pills," and like, I don't know what these do, but ok.

Olivia emphasized that when patients open up about their use of certain types of birth control, doctors can play an important role in finding the best option for a patient. She also described how this was particularly important when the patient's compliance behaviors impact the effectiveness of birth control.

To illustrate how a doctor and patient may engage in shared decision-making, Lisa role played a conversation between herself and her doctor about finding a specific type of birth control,

> "I'm going to give you this information, are you following? Do you understand? Okay, what are your thoughts? Yeah so these are your thoughts, okay here's some of my thoughts, what if we put them together…" and there may be a compromise in the middle.

Lisa's role-play and the phrase "compromise in the middle" exemplifies the goal of shared decision-making between patients and physicians. Lisa illustrated how her physician provided information, then checked for her understanding, then paraphrased what she said, creating a decision that blended both the physician's expertise and the patients' desires. This shared decision was framed as one of the potential benefits of opening up to a doctor about birth control.

Lucy described how opening up to her doctor about her inconsistent use of birth control pills allowed her doctor to explain her options, and then decide about a course of action,

> I told her I was on the pill for a while and I was just like "I'm not good at taking pills, and it's kind of getting irritating" and she's like "Okay so, here's what we could do for you…" then it was my turn to figure out like "Ok what do I want to do?" I feel like I'm very aware of my options as a woman, and I feel like, I feel like doctors … like if you ask your doctors like "What are my options?" I feel comfortable asking that question to my doctors, and then I like evaluate myself like which will be best for me and I also ask them "What do you think will be best for me?" and so I think educating myself on that kind of thing is great, but you also need your doctor's help with that.

Underlying this shared decision-making is an inherent respect for a physician's expertise, and a desire to make healthcare decisions by drawing on that expertise while simultaneously acknowledging the patient's capabilities and desires. While this potential benefit of opening a privacy boundary was important, unfortunately, a significant number of criteria involved avoiding the risks of private disclosures about sexual behavior.

Anticipating physician bias. In addition to the benefit of opening a privacy boundary, participants were weary of some of the risks of disclosure as well. These risks also informed privacy rule development. Throughout the interviews, participants described becoming aware of the larger social injustices that shape health-related communication, and this awareness influenced their privacy rules. One aspect of social injustice related to healthcare is the anticipation that a physician might hold unconscious, stereotypical beliefs about the patient based on social categories. Research has found that these unconscious, stereotypical beliefs, termed "implicit bias" affect physician decision-making and communication with patients.

Physician implicit bias has been connected to health disparities along the lines of race, ethnicity immigration status, gender, the elderly, and the overweight and obese (Chapman, Kaatz, & Carnes, 2013; Teal et al., 2012; Van Ryn & Fu, 2003). Participants in this study were generally aware of the potential for physician's implicit bias, and at times, they even used the terms implicit or unconscious bias to describe their perceptions of physician-patient communication. In particular, participants were concerned about the potential for implicit bias against them due to weight, race or ethnicity, immigration status, sexuality, and gender.

Fears about implicit bias were often described as either the result of a past experience with a physician, or an anticipation of future bias. These factors were often discussed as an intersection of overlapping factors (e.g weight and immigration status) which can denigrate doctor-patient communication.

For example, Miranda described how she believed her physician attributed all of her health issues to her weight,

> I feel like my weight has a lot to do with my doctor's [communication]. I feel like she blows off some of my issues, and is just like "Well, exercise more." I'm like "Well you're right," but I feel like that can't be the source of all my problems. So, I feel like when it comes to being a plus-sized woman, it's even harder… than "the standard" or whatever you'd say.

Miranda described how she felt that her physician unfairly attributed some of her health issues to her weight. For many patients, opening up about a health concern with their physician is an intensely vulnerable process. When this private disclosure is treated as irrelevant, and health issues are attributed to her overweight, the patient's private disclosure is delegitimized. For Miranda, feeling like she was "blown off" made her want to close a privacy boundary with a physician. Another participant, Thabisa, described similar issues,

> I used to be really big; I'm still kind of chunky now. But when I was younger, I used to have a lot of weight on me because in my household we *eat*… But when I came here [to the United States], every single problem I had would be, "It's because you're overweight." And it would be anything. I had something wrong with my nose to where I couldn't breathe right, so I would breathe through my mouth a lot. It had nothing to do with my weight, but [the doctors] were like, "If you could just lose like 50 pounds that would definitely help." Looking back, I'm like, "How would that even help?"

Thabisa, like other participants, believed that any health problem she faced would be treated as an issue related to her weight, and other potential causes of a health problem would be ignored. This perception of implicit bias degrades trust between patients and physicians, informing privacy rules.

In addition to concerns about weight bias, participants described how minority racial status might influence physician-patient communication. Later in the interview, Miranda spoke about her belief that minority groups may be treated differently by a physician,

> People of minority groups, whether it be race, or size, or sexuality, often don't want to go [to the doctor] because they're afraid, [they may think] "Oh well, like, I'm Black she's not gonna care, or I'm fat she's not going to care…" and I think that's very important…

Miranda described how this distrust of physicians could lead to a closed privacy boundary in the form of avoiding an appointment with a physician.

Another participant, Layla, was acutely aware of issues of physician bias and how overlapping social categories can create disadvantages,

> I mean, Black people are more likely to die of heart disease because doctors don't take it seriously. Overweight people's concerns of their health are dismissed and often just put on "You're just overweight." I mean, I've even had that with me. When I talked to a doctor…I really liked her but that's not the point… I would talk to her about a problem and she'd just be like, "Well, it's just because you need to exercise more. You just need to lose weight"… So, I couldn't even imagine . . . combine how I am right now with being let's say, a Black woman. I just could not imagine that. I don't know if my claims would be taken as seriously. And that's just appalling to me…I just feel like there is a lot of personal biases in doctors that they think they have in check, but they don't.

In this statement, Layla acknowledged how intersectional membership in certain social groups can create a significant disadvantage when talking about sexual behavior. Another participant, Katie, believed that her accent may result in physician bias as a result of her nationality,

> Some of the doctors, they're just going to judge you based on your race. When they say "hi" to you, or they're making first contact with you, if you open your mouth and then you have an accent, it's going to shut down for them . . . they're just not going to respect you after that. They're just making lots of assumptions and then some of them, they are just racist, basically.

In her statement, Katie described the "assumptions" that physicians make that may negatively impact her communication with the physician. In particular, she believed that

her accent would make a physician lose respect for her, and as a result created a closed privacy boundary with her physician.

Maria had similar concerns about presumptions made about a patient with an accent. A statement a physician made about her mother's English proficiency drove those fears. When asked if she had concerns about physician bias, she said,

> I mean especially about race. I can't remember how many times . . . because my mom always insists on going to doctor's appointments with me. Even at the age of 20, 21… I remember them always asking her if she needed a translator. What is it that makes you assume that, without even hearing her talk? She doesn't, she might have an accent. She speaks perfectly good English and she's very opinionated.

Maria resented the physician's assumptions about her mother, and she believed this assumption was made because of Hispanic ethnicity. This experience shaped Maria's perception of physician-patient communication, and made her skeptical of a physician's

Lisa attributed physician bias to a societal problem, such as the general stereotypes that cause doctors to "brush off" their patients,

> Because of institutions and how our society is socialized, I feel like there's definitely a bias towards women, especially when it comes to like reproductive rights, age, [and] race is a big thing in healthcare, just because racism is alive and well, thriving in the US. *Shocking* I know, but I have heard it from people getting brushed off because of their race.

Lisa noted that physicians are not immune bias in the United States, and that this bias can affect treatment of patients. This shows another example of how a patient's knowledge of implicit bias can create distrust of physician's decision-making, potentially creating a closed privacy boundary.

Another participant, Ciara, described how patients who are part of a minority are potentially brushed off,

> The physician is not gonna [admit they are biased] like "Well, because she's Black," you know? Let's, take Hispanics, for example. It's, a generalization that they a lot they don't really believe in contraceptives…. So, like from when a doctor is talking to them about certain sexual behaviors… I do think [a Hispanic person's] word is taken like this [hand gesture brushing away] …

Ciara echoed Lisa's claim that minority group status would make a patient's statements more likely to be ignored by a physician, delegitimizing the patient's disclosure.

Another participant, Lucy, described her personal interest in issues of race and healthcare,

> I'm really interested in other cultures and minorities, and stuff like that. I've read tons of papers about how Black women are not treated well at their doctor's offices and [doctors are] just like "Well yeah, that's probably not true, but go home, you're fine." I've heard horror stories about people just going to the doctor and not getting treated and they actually have a serious condition … I just feel like for girls and also minorities, [doctors] think, "Oh well, you're just naïve, and you don't know what real pain is," so they just brush it off.

Ciara later talked about how implicit biases ever-present in conversations with her doctor,

> It's always among us. I can't act like it's not. But I don't go in with the situation, like, "It's because I'm Black." When you say stuff like, "Yes, you are, you're a little overweight," which is, I'm like, "Shit, yeah, I know," like "You know, you need to you know, to exercise five days a week and okay, uh, because African Americans tend to have high blood pressure and diabetes?" And I'm like, okay, I see you're tailoring information, which is cool, because you want to give me the best options, but what information are you leaving out? You're picking your brain for things that relate to me. But how did you know that other information doesn't relate? Like how do you know, you know this and the other stuff that you would tell maybe a White woman, an Asian woman, you know, doesn't relate to me, too? . . . I know treatment for minorities is a thing… When it comes to minorities, when it looks stereotypical… as far as believing their words, I think [bias] could matter, but who's gonna say it?

Ciara tapped into some of the nuances of using stereotypes about certain patient demographics such as rates of diabetes among people who are Black. She also points out that these assumptions can ignore certain aspects of healthcare that are relevant to an

individual patient, and how a minority patient's disclosures may be taken less seriously. Kameron echoed Ciara's concerns, saying,

> I guess if people have like, racist views or something, say, a Black person comes …they might assume certain things about how they might behave sexually. Or maybe, being… not that I think this… you know, but maybe they assumed they're more careless about protection and stuff like that.

Both Ciara and Kameron expressed the difficulty of articulating the role of implicit bias in communication between physicians and patients, and the fact that it may be taboo to even acknowledge physician implicit bias.

Several participants also spoke about how a patient's sexuality might influence how a doctor might talk to a patient. Lisa described a physician's assumptions about her behavior based on her bisexuality, "A lot of people in [the LGBTQ] community are assumed to be very promiscuous, and AIDS is the stigma, like "Oh we're gonna infect you." Lisa had an acute awareness about stereotypes regarding the LGBTQ community,

> If a gay man were to come in asking about sexual things, I feel like there would be a huge shift and discomfort, because gay men are assumed to be very promiscuous and have a bunch of different sexual partners, and, also the terror of AIDS, I feel like it's very much still here, and I feel there would be a definite bias. With women… gay women, queer women are fetishized, so it's like more "normal" than gay men, and people think it's hot ...

Lisa's statement demonstrates a keen awareness of how social categories, including sexuality, can have negative consequences for physician-patient communication.

Layla also described how societal stigmas about sexuality seeps into physician communication,

> The whole non-acceptance of LGBTQ people existing… people are going to have sex no matter what. Even if you personally don't agree with it… you just tell them "I don't agree with this, but to be safe, here you go." I just think there's a lot of problems with doctors not being objective in how they feel. And I mean, like no human being can be completely objective,

> but be as objective as possible. I work in opioid addiction, and there'll be people who have HIV and have Hep-C, and I have to sit there and "I'm like, no. It's all right." There's a lot of stigmas and yeah, you can have biases, but it's what you choose to do with them. And I think a lot of doctors don't handle that well. I think that's where a lot of this shaming comes from. And I just don't think it's right. I think that's something that doctors do need to work on.

Layla acknowledged that while individuals may hold biases against certain groups, it is possible to control these biases, and attenuate the effects of these biases in communication with patients.

In addition to race, weight, and sexuality, several participants spoke about how a patient's age might create physician bias, inhibiting an open privacy boundary. When asked what would make her want to shut down when talking to a doctor, Lisa said, "I feel like, [a doctor] looking down on someone because of their age… because I'm a young woman… I don't feel like any assumption should be made just because of a person's age, whether they're older or younger." Lisa identified the fact that her young age may exacerbate an already imbalanced power dynamic between the physician and the patient.

Sabrina, and 18-year old Asian female participant, echoed this concern about being brushed off,

> I've talked to my doctor a few times, but it's just so awkward because he's a middle-aged man, and I'm a young teenage girl, so we have that the age gap that feels kind of weird, you know? And sometimes I'll tell him stuff… and then he just kind of like pushed me away from like, how I feel inside… So, I was turned off of talking to him. He ignored what I said, and he didn't take it seriously…I think the age gap made a really big difference, and that was just a really awkward because he's so much older. So, actually, I really don't want to talk to him. I think him not being open to where I was coming from just kind of threw me off, too… he just pushed me off.

Kameron described how being a young woman can lead to individuals making assumptions about her, not only at the doctor's office, but in other contexts, as well,

> I've felt that way as a, teenage girl like, not necessarily even just going to the doctor, but anywhere… I feel like, you know, like I go to get my car repaired, it's a bunch of guys. It's like you feel like they're taking you a little less seriously. Then if I went in [to a doctor's office] and they might kind of downplay girls' concerns, you know?

Kameron emphasized that this type of bias was part of a societal expectation about the gravity of young women's concerns. Lucy also mentioned young age as a factor in physician bias,

> Yeah, I feel like there is bias a lot of times with young girls and a lot of minorities girls as well. And I feel like you walk in and tell them what's going on, and they're just like "Suck it up." I feel like some doctors will be like "Oh well, you're probably just over exaggerating." I feel like there's definitely, like doctors will be like "Oh, since you're a teenager, you just don't know…

Lucy's statement echoed the sentiments of other participants who believed that their private disclosures would be given less weight because of their minority status or young age. When speaking about the role of age in doctor-patient communication, Thabisa said,

> When I go to the doctor for anything they'll kind of baby me. They'll be like, "It's okay sweetheart. It's okay, all right baby, it's going to be fine." And I'm just like, "Bro, I just need some medicine. You don't have to do all this, it's okay." They think I'm weak. It's to the point where I expect it from some doctors.

Thabisa's expectation of physician bias because of her age is another example of the erosion of trust between physician and patient, potentially thickening a privacy boundary.

Another participant, Ferni, spoke about how a physician might believe that a young person would not listen to the advice of a doctor, and as a result, would treat a young patient more harshly than they would other patients,

> The age difference… so, like a person who is young. [A doctor would think] "Oh, this kid's not really gonna listen to me, I have to be a little mean." My friend, they were ranting about a doctor that was not seeming nice, where you could open up. They were kind of just like being mean, like, oh, "This kid's gonna keep doing stupid things and not listen to me."

These descriptions show how experiences of bias can not only be found along the lines of race and sexuality, but also young age- in particular, young women.

Maria later spoke about this issue from the perspective of the physician, "I feel. . . you have to know your biases before you can even go and help someone else. I feel like either [doctors] don't know them, or they unconsciously don't know what's going on." Inherent in Maria's statement is the belief that being aware of your biases can attenuate the effect they have on communication, but if one isn't aware of their biases, they can't remediate their effect in communication with patients. Related to perceptions of physician bias were concerns about negative judgment from physicians when opening up about sexual behavior.

Fears about negative judgment. Another potential risk of opening up about sexual behavior was a physician's negative moral judgment of a patient's behavior. While the word 'judgment' has several meanings, for these participants, judgment referred to a physician forming a negative opinion of the patient based on the disclosure of private information about sexual behavior. Fear of physician judgment was cited as core privacy rule criterion that caused patients to shut down and guard their private information.

Patients were concerned about a physician's judgment about the patients' medical needs regarding sexual behavior. More specifically, participants feared physician judgment in response to their request for STI testing, birth control, and other aspects of healthcare that involve sexual behavior, including sexual assault. Lucy described her experiences in dealing with judgment from a physician after she was sexually assaulted,

> When I [was raped], if I ever felt judged, it would be from like if they were like "Oh well maybe you really shouldn't have…" like they're judging, like, "Maybe you…" because the other people that were there, the detectives and the social workers they were like "Well you just have low self-esteem, and you just have had sex with a lot of guys." So like, that part of it, like that's obviously like judgmental… they didn't say that directly to me, they told that to my mom.

Lucy described how at one of the most traumatic moments in her life, detectives and social workers who should have been helping her instead claimed that she had "low self-esteem."

Another participant, Lisa, struggled with anxiety related to the negative consequences of sexual behavior, including negative judgment from others. Lisa described her fears in anticipation of negative judgment from a physician,

> If I went to go [to the doctor to] ask about STI testing, [and the doctor said] "You know what, you shouldn't do that, because you shouldn't be having sex." That would make me feel really bad… I was so scared of talking to doctors about anything…

Lisa described how her general fears about seeing a doctor about sexual activity would be exacerbated if a physician made a statement of negative about her behavior, creating a closed privacy boundary. Lisa's description of how a physician can actually reinforce fears about sexual behavior demonstrates the role of emotion in privacy rule development. For example, if Lisa believed that a physician will invoke or worsen her worst fears about her sexual behavior, her strategy would be to avoid communication with a physician to avoid this negative emotion.

Alina's experiences as an adoptee and an immigrant meant that she faced challenges with communicating in English, and like many other participants, feared judgment from her doctor. Alina unexpectedly became pregnant at 16 years old, and described significant difficulties communicating about sexual behavior,

> I was like, "I don't even know what I'm supposed to say." Like judging type of thing. What am I supposed to think? They're going to judge me. That's when I feel like why most people keep it to themselves and don't get help, and then go online and then get it wrong.

When asked to explain more about what a doctor might do to communicate judgment, Alina said,

> The way that [doctors] look at people, you can just see… when they roll their eyes, or give you like this smirk like, "What?"" Or making you feel like you're dumb about it, for not knowing [that information] yet.

For Alina and other participants, judgment was described as being communicated through nonverbal behaviors.

Another participant also described how her interpretations of physicians' nonverbal behavior informed her privacy rule development. Ciara described how a physician might control their eye contact and the language they use to show the patient a lack of judgment, while also mimicking the inner monologue of a physician,

> Even if you are judging… we all judge, we all do, but even if that is the case you don't want to make it seem like you do. So, you're facing them. You ask, "What are you here for?" [they respond], "Um, last week I slept with three men, I only used a condom with one, and the other one had a sore" and you're thinking. "Oh, shit, she…" [pause]. Eye contact! "Ok, so what are you concerned about?" Don't come in with the elephant that's in the room, "You want to be tested?! You've slept with three men!?" So, "Ok, what are you concerned about?" Ask them "So what is it, what you like that you're concerned about?" And then [the patient] hits you with the "I need to get tested!" "And then you're like "Oh, okay, cool. So, what do you wanna get tested for? Ok we gonna do the pregnancy test, were gonna do, let's do the whole shebang, because we want to make sure that you're protected, and you're protecting others… I totally understand." So, words, words mean so much.

Ciara later expanded on the importance of perceptions of physician judgment to privacy management decision-making, saying,

> Anytime you sitting in the doctor's office and you tell him your personal business, you're in a vulnerable state. When you're open, the last thing you

> need is to feel like that your doctor's a fucking know-it-all, or that they could judge you because of your behavior. A lot of us have done silly things, but what if we didn't ask for help in our silly times, where would we be? Some of us didn't ask for help when we did those silly things and we had to go through that again, so you don't want that… making sure that you're not judging and you're being open with them is asking them questions.

Ciara emphasized the patient's vulnerability and the importance of a physician being open to receive patient's disclosures about sexual behavior.

Like Ciara, when asked which physician behaviors might signal judgment, Mary also spoke about the importance of physician nonverbal communication. Mary told a story about her doctor's reaction to her disclosure that she no longer used condoms with her fiancé,

> I was in a long-term relationship. We were engaged, we moved in together. We stopped using condoms. [My doctor] asked "Are you using condoms when you have sex?" I told him "No, this is my scenario." He's like . . . "Well, you don't know what he's doing." It's like, "But I kind of do." So, that was kind of a sign of a judging. The big huffs. I'm sitting there talking and it's [like he's huffing] while I'm on the little observation table. I caught him shaking his head down. I'm like, "What are you shaking your head to?" Because that just kind of makes me think I've said something that he goes against. So, I think it is hard for [doctors] to not be judgmental.

These participants described a fear arising from both the anticipation and experience of negative judgment from the physician. This fear of negative judgment may be heightened by the power differential between patients and physicians. Research shows that patients try to interpret the physicians' perceptions of the patient as a result of this power difference, and this difference may make the patient particularly attuned to the thoughts of the physician (DiMatteo & Taranta, 1979; Goodyear-Smith & Buetow, 2001; Mast, 2007). Given the vulnerability of private disclosures of about sexual behavior,

participants were also concerned about their private disclosures being delegitimized after they opened up about these topics.

Fears of delegitimization. As described in an earlier section, participants were concerned about being delegitimized because of minority status, however, some descriptions of delegitimization were not explicitly linked to minority groups. Some of the women expressed concerns that when going to a doctor for health care, their doctor might dismiss their private disclosure about sexual behavior. When a patient makes themselves vulnerable by opening a privacy boundary about their worries about sexual behavior, and is subsequently dismissed by their physician, this dismissal fails to recognize the patient's vulnerability. As a result, the risk of this dismissal served as a catalyst criterion for privacy management, creating a closed privacy boundary. Ferni talked about her concern that speaking about sexual topics with a physician might result in being shut down by a physician,

> If the doctor really seems interested and concerned and that they'll listen to you, you'll easily be able to talk to them… if they don't just toss aside whatever you have to say, like, "Oh, it's nothing," or something like that. It's just like, "Oh, I thought it was important, okay."

Ferni went on to describe a previous experience with being brushed off, and how her doctor ignored her concerns that her problems with her period would affect her fertility,

> I have problems with my period, like I would cry when I'd get my period, and I would not go to school, it would be really bad. And I brought it up at the doctor's, I told my mom, like, "I can't keep doing this like just, like, this hurts really bad." And I told my doctor, and he was like, "Oh, it's okay, like normal periods are like that, you know, you're going to feel pain." And I was like, "This hurts!", and he was just, like, "No, you're fine." I was like, "No, it hurts," like, he wasn't listening to me at all. It could be that [he's a male doctor], or he just doesn't know… But I feel like a doctor should know, because I know it could be really bad. My neighbor, she had a problem with her period, and now she's not able to have kids….

> So, I would think that a doctor would know when it's serious if they're generally concerned [with the patient].

For Ferni, her anticipation that a doctor might brush off her concerns was based on a prior experience with a doctor. While she was not talking to her doctor specifically about sexual behavior, Ferni used this example to describe her overall concerns about opening up to her physician.

Another participant, Thabisa, described how a language barrier led to a physician's frustration, and being brushed off,

> With the English thing, when I go to the doctors and my mom or my dad is seeing the doctor, they have a very thick accent. So, I'll see the doctor kind of like, brushing off what they're saying. And then they'll say a word that the doctor can't understand and then he'll be like, "What?" And he'll kind of get frustrated with them for not being able to say it correctly, or say it with an accent from here. And then I'll have to intervene, like "They're trying to say this."

Thabisa felt a responsibility to translate between a physician and her parents, creating a perception about physician's frustration with patients who have "thick accents."

For some participants, a physician "brushing off" a patient can result in the lost opportunity to receive care. Ciara spoke about her experiences supporting a friend who sought care for sexual assault,

> Someone very close to me… she's very closed off when things like this happen… and I know she needs help, but the way [the doctors] went about it, it was kind of a pat on the butt, and they [dismissively waves to the next patient], you know? And she didn't get the proper care she needed.

Another participant, Mary, talked about how a physician brushed off her concerns about a latex allergy,

> I'm somebody with a latex allergy, and that was something I had to prove to my doctor. He did not take my word on it. He was like, "Well, how did you know?" I was like, "Well, I had sex with a latex condom and it was awful." He was like, "Well, you probably weren't doing something right.

> The condom was probably dried out. You probably were not wet." It's like, so the hives and irritation and rash, that's just normal. He was like, "How do you know that's not a disease?" Then so he actually made me go get a latex allergy test, and then once I did he was like, "Oh, you are [allergic to latex]. Okay." But then he never really told me like, "Here are your options." I just kinda went to Walmart and looked at which one said non-latex . . . I didn't know lambskin condoms could prevent pregnancies, but I did not know they could not prevent STIs… I think if you do have something along those lines telling them you had a bad reaction to a birth control, and again it's like they don't believe you. They're like, "Well, it could be something else." It's like, "Well, it's been going on for six months," I was really watching my diet, trying to just do different trials. He was like, "Well, are you sure?" Believing is one thing I think is something I would want doctors to understand is taking my word for it.

Mary's statement speaks to the struggle for her private disclosure to be believed by her doctor. For Mary, her doctors' disbelief about her latex allergy caused her to seek out non-latex, lambskin condoms, which unknown to her, do not prevent STIs. This missed opportunity for education about alternatives to latex condoms illustrates some of the potential health consequences of being "brushed off" by the doctor. For these participants, there was a salient fear about opening a privacy boundary, and then having their private information being dismissed as insignificant. Sharing private information about sexual behavior leaves the participant vulnerable, and to delegitimize patient's concerns is a form of privacy turbulence.

Physician discomfort. Participants spoke about how one significant risk of disclosure was the potential for a physician to be uncomfortable with learning the patient's private information about sexual behavior. Research shows that at times, physician's emotions may create discomfort and interfere with their ability to communicate about sexual behavior with their patients (Epstein et al., 1998). This discomfort is a significant barrier to comprehensive physician-patient communication about sexual behavior (Epstein et al., 1998). Participants described how a physician's

reaction of discomfort signaled the physician's role as a reluctant confidant, consequently informing the patient's privacy boundary coordination. Petronio (2002) explained that a reluctant confidant is often unequipped to handle an unexpected disclosure, leading to potential consequences for privacy management. Participants often described a physician's visible discomfort in communicating with patients about sexual behavior, using terms such as embarrassment, awkwardness, and "making the patient feel bad." Despite the fact that discussion of sexual behavior should be expected in physician-patient communication, a physician's reaction of discomfort signaled a breakdown in privacy management processes.

Thabisa explained why she held a closed boundary about some aspects of sexual behavior with her doctor,

> I only tell the doctor what they need to know about what they need to diagnose. And I only tell them that [much] because they are capable of diagnosing me, and actually treating me. But if it was just a matter of just talking to a doctor, I probably wouldn't. Because it's just not comfortable. The doctors I've been to, they're not very comforting about stuff, or show interest in your actual person life.

Thabisa described her own discomfort communicating with a doctor, and how she decided what information she chose to share, based on the risk of discomfort. Earlier in the interview, Thabisa demonstrated a good understanding of STI's and other aspects of sexual behavior. However, her confidence about her knowledge of sexual health, in combination with a guarded privacy boundary may actually be to her detriment. For example, in the future, if Thabisa assumes that certain symptoms are always a UTI, she may not open up about other aspects of her sexual history, like a new partner, or new sexual practices, which may have bearing for concerns about an STI.

Layla spoke about physician discomfort, and specifically attributed physician discomfort with the stigma surrounding STIs,

> I don't tell my coworkers how I feel about STDs or HIV, because it's not going to affect how I treat anybody. And I think a lot of doctors do not have that mindset because they view it as a stigmatized disease. A lot of people view sexual behavior as just something that's not talked about. It's like, you're a doctor. You do the entire body. Newsflash, genitals are part of that. I think a lot of doctors really struggle with that, in getting over their own personal embarrassment of it.

Layla emphasized that she believed that it was part of physician's obligation to overcome discomfort associated with communication about sexual behavior. However, like other participants, Ciara described how her physician's discomfort with communication was manifest,

> So, [doctors are] a little awkward, we know doctors, they are. Sometimes they're too nonchalant, and sometimes they just overly… honestly, they need specific training from somebody that understands how to evoke emotion and help them understand. Because they just want to treat people, and that's how they help, and we need them for that. But they don't understand.

Miranda went on to acknowledge the consequences of not seeking care because of patient discomfort,

> It can get really hard. And we need to just, I almost want to say, like, we need to get over it. But you can't just, like for some people it's so hard. I have a friend that's avoided the doctor for years, just 'cause she doesn't like, it she's afraid that they're going to make her feel bad. And I'm like I understand, because me too, but it gets to a point when you do need to go regardless of how shitty they're being.

For these participants, discomfort regarding communication created a privacy rule to withhold information about sexual behavior. Notably, even participants who spoke about personal discomfort with communication related those feelings to the actions of their

physician, and several statements were based on an underlying belief that physicians are responsible for the communication climate in interactions with their patients.

Confidentiality breach. Some participants were concerned about the confidentiality of their private information about sexual behavior. Fears about the risk of a breach in confidentiality served as a core criterion for privacy management. Jordan said that while she had a good relationship with her doctor, she acknowledged that some college students may be concerned that their private information would be communicated to their parents,

> I feel like some college students, they would want to not go to the family doctor, just in case. I know there's that doctor and patient confidentiality, but I still I would be afraid that maybe they could say something my parents or hint towards my parents. Maybe [some patients would] go to a clinic if they were in college. And I would do that if I didn't have good relationship with my doctor. I just heard that sometimes people don't want their parents to find out that maybe they're getting on the pill or getting some kind of birth control, and then you have to go through like insurance, or you have to somehow go around it or get it for free.

For Jordan, the relationship she had with her doctor acted as a safeguard against a breach of confidentiality.

Maria described how she sought out birth control that can be shipped to her home to ensure that her mother wouldn't find out about her prescription,

> I actually looked into [home delivery for my birth control] because I didn't want to go through my gynecologist, just in case, because I know my mom access to my information. If she were to call in, I don't know how much they could tell her, so I was like, "I'd rather not go down that route."

Maria's method of acquiring birth control may avoid confidentiality breaches, but also misses the opportunity to reap the benefits of communicating with a doctor, such as shared decision-making about birth control.

Simply the act of taking notes of the interaction between doctors and patients may foment concerns about confidentiality. Jasmine described how a patient might be concerned about a physician recording their conversation,

> If the doctor made them feel like they can talk, they'll open up more, and if they know it is only between them, it could be kind of like a trust things…[but] they might shut down if they have really bad trust issues, and they don't trust the doctor's gonna keep it to themselves, and especially if the doctor's writing it down, [they'll] say less stuff because they [think], "Oh it's going to be put in this [record], how do I know someone else is not going to see it?" Yeah, and if there is a betrayal…

Participants were particularly concerned about their private information about sexual behavior being revealed to their parents, and were willing to take measures such as maintaining a closed privacy boundary and seeking birth control prescriptions online in order to avoid this risk.

Physician's communication competence. Individuals often monitor confidant's behaviors when deciding whether to open or close a privacy boundary. For example, in communication between physicians and patients, it is common for patients to interpret the behavior and thoughts of their physician. An early exploration of the criteria for self-disclosure identified some prerequisites for self-disclosures in medical encounters. These prerequisites include: setting, receiver, sender, and relationship (Petronio, 2002; Petronio, Martin, & Littlefield, 1984). The study found that for both women and men, receiver characteristics were rated highest in importance when discussing sexual topics. Survey results demonstrated that women in the study preferred a receiver who was "discreet, trustworthy, sincere, liked, respected, a good listener, warm, and open," and wanted to feel that they would be accepted, not feel anxious, or provoked into giving information (Petronio et al., 1984, p. 217).

In healthcare, physician communication competence has been found to influence patients' willingness to communicate, but has not been explored specifically with the frame of CPM theory (Baker & Watson, 2015). In the current study, perceptions of physicians' communication competence catalyzed the creation of privacy rules and at times led to recalibration of privacy rules. The seven physician communication skills that shaped patients' privacy boundaries included the use of checklists and multi-tasking, 'remaining human' in communication with the patient, the use of transitional phrases, asking and answering questions, physician disclosures, the use of humor, as well as non-verbal indicators of competence.

Checklists and multitasking. At times in doctor-patient communication, a doctor may use a checklist to guide communication with a patient. The use of checklists in physician-patient communication are purported to reduce diagnostic errors, particularly in scenarios where there is limited time (Ely, Graber, & Croskerry, 2011; Gawande, 2010). However, some participants noted that the use of a checklist can impede an open privacy boundary.

One participant, Sabrina, talked about how her physician would use checklists and multi-task during their conversation,

> I couldn't really talk to him, because they're just like trying to get things done. They have a checklist so they can't really talk, and then they're done with that, and then they just leave. I think *holding conversations* as they're doing their procedures and multitasking makes the patient feel more like, "Okay, I'm like getting through my checkups, but I'm still opening up to my doctor about how I feel," and I think that just helps…

Sabrina explained that it was important to create a balance between the use of a checklist and having the space to open up about other contextual factors, such as her feelings.

Another participant, Ciara, told the story of trying to receive a diagnosis for a women's health issue,

> For example, I don't mind telling you this… I don't have regular periods… I felt like a freaking test dummy … They tried four different methods to see what it was, and there was no follow-up … So, if you want to talk to a physician, you can't go off what they think, it's your body. I think one thing that patients should pay attention to is themselves. Pay attention to your body, to what your concerns are, don't let… sometimes doctors have a bad habit of going "no, no, no, [mimed using a checklist], so then you run down [the checklist] and tell them all these things and they're like, "Ok." But what if I don't pay no attention to myself? Because I've been through this type of thing, I understand how you could be discouraged as a patient, you have to really ask questions.

Ciara described the importance of being in touch with one's own body in order to assert her concerns to the physician and feeling comfortable asking a question. Jordan also described how the use of a checklist can create a sense of limited time,

> Mostly [doctors] just come in and they're just like, "Hi, how are you?" Okay. "Let's check your eyes, your ears, your nose and all that, and, ok, do this, this and this and this" and then in between they're trying to do other things, and then they'll ask you about your life, so… I just, I know they all have busy schedules, obviously. But like, I feel like they could give more time and spread out the patients a little bit more, that way if a patient does need to talk to a doctor, then you can open up. Because if I feel like I'm in a rush, then I won't say anything. It's their go-to, a checklist.

Emma also spoke about the importance of asking the patient questions outside of the structure of the checklist,

> It feels there isn't a lot of time if they don't ask any questions like, "Does this make sense?" or, "Do you have any other questions?" Like if you don't ask that, like you are you really, like, caring for your patient one hundred percent? Because [the patient] might have things [about sexual behavior] that they're too scared to answer because you're just going like this [flipping through checklist]. So sometimes [doctors] have to slow down because most people who are patients are not doctors, they don't understand what's going on. Just, slow down.

Emma echoed the comments of other participants, who emphasized that there are aspects of their lives that may not be addressed by a checklist and yet are relevant to ensuring complete understanding of the patient's health.

"Remaining human." Several participants emphasized the importance of physicians "remaining human" in their communication with patients. This theme was described as a strategy that would affect how a doctor treats the patient. In other words, how the doctor thinks about the patient (i.e. as a human, or as a simple medical diagnosis) shapes communication with a patient and serves as a catalyst for either opening or closing a privacy boundary.

For many participants, it was important that the physician retain their humanity in communication with patients while recognizing their patient's humanity. Lisa said, "Remaining human and communicating in a way that shows that you are a person is really important and super underrated." Another participant, Lucy, also emphasized this "human connection," saying "I feel like… [patients] are like 'Oh, they're just a doctor what do they know about me, a real person?' I feel like there's a little bit of that like mindset that doctors don't actually care about you as a person."

For Layla, "remaining human" meant recognizing that the "patient is a person. In the following statement, Layla described "treating the patient as a person" as a potential strategy for creating an open privacy boundary between doctor and patient,

> I wouldn't open up to a doctor about sexual behavior because… you don't know their stance on things. I definitely think if doctors want to have a good, honest discussion about [sexual behavior], they have to adopt the philosophy of "a patient's a person." I know it's very hard for some doctors to adopt that philosophy. I know doctors don't always have all the time in the world to do that, but I mean, it's just like a basic thing that makes someone more likely to tell you something… I feel like a lot of doctors have this "Well, I know better than you" [perspective], or they're very

> quick to dismiss [you]… I feel like a lot of doctors could benefit from . . . for two minutes, just dismissing their medical knowledge and just talk to a human being. Just for two minutes, just sit down and be like, "What is this person feeling? Why are they feeling like this? How would I feel if I felt like this?" That's just being a practitioner of medicine. You have knowledge, but you're not being a doctor. You're not dealing with a human being, you're just dealing with a diagnosis or disease. That's not how it is to be a doctor. Sorry, news flash.

In her statements, Layla emphasized that the role of the doctor should go beyond simply using medical knowledge to diagnose patients, and also should seek to understand the larger context of a patient's life.

Katie echoed the importance of "remaining human," and provided a definition of what that means to her,

> I think that [doctors] should just treat everyone like humans … I think the doctors, they should make their habit to becoming nice to patients … Basically you're their customers, so if … I know that they are the doctor, they worked hard for it, but you are human too, so they should just put themselves in our shoes, too. If I'm just going to treat him nicely, so I would he should treat me nicely, too.

Katie explained that a doctor "putting themselves in the patients' shoes," by attempting to empathize with the patient can not only change how the doctor views a patient, but also change how they treat a patient.

Maria talked about how a physician may see her as a diagnosis, and "not seeing her as human,"

> I feel like I'm a very open person. But, the second they make me feel like, "Oh, [the doctor is] going to think strictly medically about that and not think about [me as an] actual person, I'm just like, "Okay, why bother even telling them?"

Mary contrasted the doctor "treating the patient as a person," with "thinking strictly medically" about the patient. For Mary, this perception of the doctor created a closed

privacy boundary. When asked how physicians might mitigate implicit bias in their communication with patients, Mary again described treating the patient as a human,

> Being able to put themselves in other people's shoes type of thing. Just having that double-view . . . Being able to understand that people are going to have different reasonings, and thoughts, and opinions, and backgrounds, and culture and stuff like that… being able to just look at those different perspectives and be like, "Okay, I see where you're coming from." It's like I can see why you made these decisions. Just being understanding of that… They were raised different than you were and they have different education than you do. They have different environments that you do. So, it's you're 100% different.

Mary's description of the "double view" encompasses the sentiment of other participant's statements about the need for doctors to treat the patient as a human. By integrating understanding of the patient's unique experiences into the interpretation of a patient's health concerns, a physician can create a communicative space where the patient feels they can open up about sexual behavior.

Transitional phrases. Use of transitional statements is an integral component of physician's communication skills (Maatouk-Bürmann et al., 2016; Williams, Weinman, & Dale, 1998), in particular, communication about sexual behavior (Epstein et al., 1998). Participants often remarked that they preferred their physician to use transitional phrases to ease into communication about sexual behavior. This preference is consistent with extant research that describes the importance of physicians using transitional phrases to introduce topics surrounding sexual behavior (Epstein et al., 1998). This preference may be explained by the fact that awkward transitions demonstrate a physicians' discomfort or lack of communication competence. As a result, a physician's competent use of transitional phrases was cited as a potential catalyst criterion for opening a privacy boundary. One participant, Miranda, said,

> It's easier for me when they lead [the conversation]. I want them to bring it up so that I know like "Okay, I can talk about that." I feel like that's a lot of easier just having to like come forward with it yourself, because starting that conversation is even harder than just having it.

Miranda explained that when a physician initiates communication about sexual behavior, there is an underlying message that the discussion is "ok."

Ferni also described how a physician initially broaching the subject can give the patient permission to discuss sexual behavior. When asked how she felt about physicians initiating this communication, Ferni said,

> It would be nice, because then it would just be like, "Okay, I guess I can talk about it then." It also shows like they're trying to help you. It doesn't even matter if [a question about sexual behavior] doesn't apply to you, as long as they're asking questions that make them sound concerned for you, and your health, and your wellbeing, you feel a lot better.

Ferni reiterated that a physician initiating communication about sexual behavior can create a more comfortable communication space and show that the doctor-patient interaction is an appropriate space for communication about sexual behavior.

However, not all of the women were supportive of the use of the transition, "I ask all my patients this." Participants described how a doctors' transitions can be either successful, or unsuccessful. Jordan had an issue with the phrase, saying,

> I don't necessarily like it. I mean, you may *have* to ask everybody it, but you don't have to say that you do… just ask the question…because each person wants to be treated differently, and feel like the doctor pays more attention [and] can focus on them over time, instead of thinking about the ten other things they have to do with the time.

Alina also took issue with certain transitional phrases and described how a physician should communicate with a patient to help them open up,

> Just come in, introduce yourself [and when the patient] comes in, they ask you about this history, if anything changed, that's a good thing. Because it tells you if the person has changed or anything. I feel like it's nice if

> doctors come in and talk to you, ask you for your stuff and what's going on, and then you just tell them what's going on and everything.

In her description of a physician's transition to talking with the patient about sexual behavior, Alina spoke about the importance of introductory statements, adopting a more personal approach, and taking the time to learn about any changes in the patient's sexual history. While checklists and transition statements are part of training physicians to communicate with patients, participants described a different, counter-intuitive communication strategy that was described to impede patients from opening up about sexual behavior.

Asking and answering questions. Participants were aware of physicians' communication competence. Perceptions of a physician's communication incompetence were cited as potentially leading to a closed privacy boundary. Participants described one counterintuitive and counterproductive pattern of physician communication when physicians would move through a checklist about the patient's social and sexual history and simultaneously ask and answer questions in a monologue. This communication strategy signaled a physician's discomfort and desire to change the subject, and gave no recognition to what the privacy issues were for the participant.

In Ciara's earlier description of the use of a checklist, she emphasized how some doctors would answer their own questions on a checklist saying, "Sometimes doctors have a bad habit of going "No, no, no," [mimes checking off questions on a checklist], so then you run down [the list] … "

Thabisa also identified this pattern of asking and answering questions in her experiences communicating with her doctor,

> My mother found [this doctor], and she just I guess she liked the way he was conservative. He'll assume that just because I'm 18, I'm not married, and I'm not supposed to have a boyfriend, so "I'm not pregnant, I'm obviously not pregnant." So, he won't test for that. So then now I'm wondering, "Okay, what if I was?"

In Thabisa's earlier description of the same doctor ruling out pregnancy, the physician answered their own question, saying "pregnancy isn't possible." However, privately, Thabisa was concerned that she might in fact be pregnant.

In another example, Lisa also described how a healthcare professional simultaneously suggested that she may be pregnant, while asking and answering her own questions about Lisa's sexual history,

> I have, like, a very bad issues when I'm on my period, like I get very sick each time. So, I went to the nurse and I was like, oh, my goodness, I think I'm dying, and she was like, "Oh, well, let's, make sure you're not pregnant. Oh, you're not pregnant, that would be a 'No'" And I was like [overwhelmed facial expression]. And then she's like "Oh are you sexually active? No, you practice safe sex, you're not pregnant at all." And then there is just like a stigma against that, and I was like "I mean I hope I'm not pregnant, like I am literally on my period, I don't think I am" but also just like the assumption because like I'm young, she was like "No you don't, whatever" and I was like okay, if I was [pregnant], for me personally, it's a terrifying thing to get pregnant when I'm young. Like that's terrifying. So, like when she confirmed a deep fear and then also made me know that I would be lesser if I was, I was like, "Ahhh… what if I am? I'm literally not, but what if?" Then I just started going into panic mode, and I was like, I need to leave.

For Lisa, this communication pattern of asking and answering questions for the patient signaled that these answers were the "correct," "desirable" answers. Not only does this style of communication stymie the patient's response, it also reveals physician bias, and may reinforce patient fears about the deviance of their behavior.

Physician disclosures. In the interactions between physicians and patients, at times, physicians will reveal their own private information to the patient (McDaniel et al.,

2007). Research has shown that generally, reciprocity is the strongest predictor of disclosure (Petronio, 2002). However, one previous study observing primary care physicians found little benefit to physician disclosures in the physician-patient interaction (McDaniel et al., 2007). In the current study, some private disclosures were relevant to healthcare, while other examples were not. These appropriateness of these types of physician disclosures were described to signal physician competence and informed the creation of privacy boundaries. The women in this study also pointed out that skillful physicians should be aware that personal stories can have an element of emotion which may be more persuasive than other types of information. For example, Lisa stated that her general fears about seeking healthcare for sexual behavior would be allayed by a physician opening up about their own experiences and private information,

> If you were going in [to the doctor] for birth control (very relevant because I want to start being on birth control) ... But, I'm very scared about it, so going to a doctor and being like "I want to get on birth control but there's a lot of things I'm really scared of," [and then], a doctor saying, "When I got on birth control for the first time this is what happened…" Not a horror story, but like, "There are positives and negatives, but at the end the day…" or "I remember the first time I went to a doctor asking for something about this, and I was really scared, so I really appreciate that you're actually willing to open up with me." Something like that, pull in personal history…just to make it more relatable and more human, normalizing it. I think would be a really good thing.

Lisa believed that her intense fears about birth control and issues of safe sexual behavior in general would be reduced if a physician normalize her fears by sharing personal experiences. Jordan echoed this sentiment, saying,

> [A physician sharing personal information about a health condition] helps the relationship… sometimes is that I think it helps because it shows that it's happened to them before and like, you can overcome the issue, whatever it may be. So, I think it also it helps build the relationship, knowing that you're not the only one that's going through that… has been through that.

Jordan explained how a physician's private disclosure could not only normalize the patient's experience, but also build the relationship between a doctor and a patient.

Another participant, Alina, described how a physician opening up about their own personal information may act as a safeguard against experiencing judgment,

> I would be fine with [a doctor disclosing private information], just because it connects on the personal level, and it does make the patient open up a little bit more, because they don't feel threatened that you're going to judge them.

Her statement reflects Jordan's opinion that it improves the personal relationship between the doctor and the patient, and also shows that similarity of experience can act as a safeguard against judgment, thus opening a privacy boundary.

However, not all reactions to a physician disclosing private information were positive. At times, participants described how physicians' private disclosures could also signal communication incompetence. Kameron raised issues with how a doctor's emotion can shape how they present medical information,

> I think it's probably not a good idea [for a physician to disclose personal information]. I think probably because you could be a little… maybe not biased, but since it's personal, you might exaggerate a little or something, or to try to scare people away… Maybe [they should] just us examples or like statistics or something rather than personal story.

Kameron described how a physician's emotion can disproportionately influence a patient's perception of treatment and prevention options. Ferni also described where a line of privacy boundaries can become inappropriate,

> I feel like if anything gets too personal that it gets to the point where you don't really see them as a doctor…I feel like in that moment when you're at the doctor's office, you have to think, you know, they're the doctor, and they're here to help… They have that authority, but as soon as they start talking about stuff that is super personal, it is kind of just like, "Ok." Anything that doesn't have to do with what you're talking about, like

> what's really important, and anything that's like, distracting from the actual problem.

Ferni pointed out that a physician's private disclosure that is irrelevant to the health issue could serve as a distraction and may degrade the physician's authority.

Layla told a story about a time when a doctor shared personal information about their own experiences,

> I had a doctor, probably four years ago. She was so sweet. I was having these really bad headaches… I went to her and I was like, I don't know what's wrong with me… we did a brain scan but nothing was wrong with me…and she was like, "I think your emotional stress is what's causing these headaches." … She was sharing her personal story, because this was like a year after my dad had died, and she was sharing the story about when her sister had died. And then she cried with me, and I was like, "Whoa, okay, wasn't prepared for that one." But it was really nice. I still don't agree with the fact that my headaches were emotional. I just really feel like it is helpful when doctors do share their own feelings. But then at the same time they can't make the mistake of using, well, "I went through this and that didn't happen, so that's not this." You gotta walk that fine line of sharing it, but not invalidating the other person's response to what they're feeling… or, "I've had a similar experience, or I know someone who's had that…" It's like, cool, that's great. Everyone's different.

In Layla's experience with her doctor, the disclosure served to create a stronger relationship between the doctor and the patient, and yet Layla felt that her doctor had made the error of transferring her own experiences to Layla's health problem. While this experience didn't deal specifically with sexual health, it did inform Layla's overall perception of physician disclosures.

Another participant, Juana, talked about how a physician disclosure can have both positive and negative effects,

> I can see the pros and the cons of [physician disclosure] because you could hear good stories and you could learn horror stories. Second… your body is different than hers. So that plays an effect too. But like, because I really like a [physician providing] personal information because that makes me feel like I'm like I'm spilling my guts less. So that helps.

Like Layla, Juana also felt that a physician's personal experiences may be unduly applied to the patient, yet felt that a physician disclosure could reduce a patient's sense of vulnerability.

Mary also described some of the pros and cons of physician disclosure, addressing how certain disclosures may cross a line or be inappropriate.

> As long as it's relating to the issue and it could help me see a different reasoning or a different perspective I would [appreciate physician disclosure], but if they're just like, "Oh yeah my wife cooked chili last night." It's like, okay cool. What's that gotta do with me talking to you about why sex hurts? …And I don't want to hear your horror stories. I don't want to hear "This girl got the [birth control implant] and she had to go into an emergency surgery to get it out, because we couldn't get it out with the simple outpatient surgery. She had to actually go in and get her arm dug out." It's like I don't want to hear that … I don't want to hear that I may have absolutely these God awful reactions….

In this statement, Mary explained how a physician's story can vivify some of the negative side effects of birth control. Like other participants, she also points out that a physician's private disclosure may be welcome in certain circumstances, but should be relevant to the health issue, and avoid creating excessive fear in the patient through "horror stories."

Appropriateness of humor. Similar to physician disclosures, participants had varying perceptions of how physicians might use humor in communication with patients. Use of humor was framed in the context of communication competence and underscored how use of humor influences whether a patient felt comfortable opening up about sexual behavior. Some participants emphasized that perceptions of humor are individual. Alina said,

> I mean [humor is] fine, as long as I feel like he's going to be careful, because I have a sense of humor, and I know when people joke around or not, but some people are not like that. So, they'll get offended. It just all depends on the person.

Ferni also emphasized that perceptions of humor vary from person to person, and described when humor wouldn't be appropriate,

> I feel like it's a personal preference because, like me, if I already know what I'm coming in for, I just want to know, like, I just need to be like, "This is what I have. This is my problem. And can you please help me?" I just want to have a serious talk, "How could we have this [health problem] fixed? How can you help me feel better?" Not doctors joking around… but some people may find comfort in that.

Ferni's statement emphasized how using humor might interfere with receiving health care and distract from the seriousness of her problem.

Another participant, Kameron, explained that humor is a tricky tightrope, particularly in discussion of sexual behavior,

> I guess it depends on the kind of humor… I mean, sometimes humor is appropriate. And sometimes it isn't… if they were maybe humor about, you know, vulnerable sexual things, that's not appropriate, but if he's kind of like, when they get to know you in other ways, if they kind of joke around about unrelated things, I think that's a good way to kind of ease the tension. Yeah, but not humor related to the reason that they're there, I guess.

Kameron preferred to have humor be unrelated to her health problem, as a means to ease the tension. Thabisa also talked about the delicate balance of humor,

> It depends on what I'm in there for. If it's something serious, then I don't think we should be cracking jokes. But if it's something kind of common, then that's fine. Because I kind of like it when they have humor, so I know that I'm not talking to a robot, they're actually there with me.

Thabisa's statement is related to the theme of physician's humanity, the idea that humor can create a sense of presence between the doctor and the patient. Mary also described how humor can break any tension in communicating about sex, but that it is important for the patient to have the opportunity to fully describe their sexual health concerns,

> I don't mind if you feel like something a little awkward like you're having that first time of talking about sex, if it's a little awkward, I wouldn't mind if you're cracking a small joke but I don't want the whole entire time to be a joke or humorous or this and that. It's like I actually have concerns. I actually have questions. I actually have things I want to talk about and I don't want to be like, "Oh yeah. Haha. That was funny."

While some aspects of physician verbal communication were described to break tension or build the relationship between physician and patient, inappropriate humor was described as having the potential to denigrate the relationship between the physician and the patient, particularly racial or political humor. Juana explained,

> I think that [humor] could be tricky because everybody's humor is different. And what if someone takes complete offense… But I like humor, so I'm all about it. It's just hard, you'd have to have, like, a certain knock-knock joke you could use for the rest of your life. [With] race, immigration, I think politics is also like a really tricky topic these days… I think, in this society everybody wants to be understood… I feel like you have to be very like, "This is all the jokes you could use," you know?

Juana tapped into the fact that some jokes may be at the expense of certain groups along the lines of race, immigration, or politics, in turn alienating the patient. When comparing participant's perspectives on physician disclosures and humor, it was emphasized that patient's preferences are unique to the individual and were generally acceptable to the extent that they didn't distract from the concerns of the patient. In addition to verbal communication, physician nonverbal communication played an important role in privacy boundary rule formation.

Nonverbal indicators of communication competence. In the context of privacy management, nonverbal behaviors are often used to mark privacy boundaries (Petronio, 2002). Nonverbal behaviors play a particularly important role in communication; it is estimated that up to 60% of meaning in social interaction is communicated nonverbally (Burgoon, Guerrero, & Floyd, 2016). Further, nonverbal behavior is often used to

extrapolate other's true thoughts and feelings, and is weighted more heavily when compared with contradicting verbal communication (Burgoon et al., 2016). For example, if a physician professes to be comfortable treating LGBTQ patients, and then sits far away from the patient, the nonverbal behavior will be weighted more heavily. A physician's ability to competently use nonverbal communication played an important role in whether the participants felt comfortable opening up. Women in the study often described trying to interpret meaning from physicians' nonverbal behaviors, including eye contact, body language, and tone of voice. This interpretation was part of an effort to glean the level of physician discomfort and communication competence, which informed the opening a privacy boundary.

Eye contact. Participants described how eye contact (or a lack thereof) was treated as meaningful in the doctor-patient interaction. Ferni described how a lack of physician eye contact signaled disinterest in the patient's concerns about sexual behavior. Ferni said, "I feel like when you're trying to talk about the problem or a concern, if the doctor isn't really looking at you, or really, looking like they're 'in the moment,' they're not paying attention."

Several times over the course of the interview, Thabisa described her perceptions of physician discomfort. When asked what factors make her think a physician is uncomfortable, Thabisa replied,

> They'll like be looking down at the history, or whatever it is … and they'll just be looking down, and then talking to you. They don't make eye contact or anything. They're just reading off back to you what you're saying, "You had this, you did that, okay, all right" … So, I'm assuming they weren't interested in me.

Thabisa described a physician taking notes that inhibited eye contact, but also believed the deeper meaning of a lack of physician eye contact was a lack of interest in her as a person.

Julie also talked about how a doctor looking at a chart or checklist can inhibit eye contact, “The doctors never really seemed to care … that you actually had a problem. They didn't make eye contact. They just kind of looked at their [chart]. They just didn't seem to want to, like, fix anything.” Once again, this participant interpreted a physician’s over use of the medical chart as a lack of interest in the patient.

Maria also described how her physician would not make eye contact when she was speaking about her health concerns,

> Whenever you gave him information, he never really looked at you. He just stared at his laptop and was writing down notes. “Are you listening to me?” so I guess just looking at you, acknowledging that you're talking, eye contact … It makes me stop to think, "Oh, did they react that way because they disagree with what I'm saying, because they're thinking about something else, or am I doing something?"

When trying to interpret her doctor’s lack of eye contact, Maria inferred that her doctor may have had a negative reaction to what she was saying in the interaction.

When asked how a physician can communicate compassion, Sabrina said, “I think just the way you talk to them, like face to face, your body language… making eye contact, I think eye contact is really important.” It is important to note that a lack of eye contact can be the result of many different factors, such as physician tiredness, over-reliance on scripts, or other factors. However, for these patients, eye contact was interpreted as having something to do with their interpretation of the patient. In addition to eye contact, participants also described interpreting physician’s facial expressions.

Facial expressions. Certain facial expressions were interpreted as signaling a physician's negative judgment of a patient. Jasmine described how opening up about sexual behavior might elicit judgmental nonverbal reactions from a physician,

> If someone says, like, "I did this [sexual behavior]," then [the doctor's] face can like turn up in a different way, like their eyes scrunch and then you could tell that their face is disgusted by it. And then you can tell … if they're judging your or not, because their body can shift, in a certain way, and if they don't feel comfortable, if they don't like what you're saying.

Jasmine's use of the word "disgust" and her inference that the physician is uncomfortable illustrate the importance of physician's reactions to the patient in communication about sexual behavior. A fear of creating disgust with a disclosure is a significant risk, leading to a closed privacy boundary. Another participant, Jordan, also believed that facial expressions served as a signal of physician judgment,

> I think if [the doctor] gave them a look. Or maybe, like, judging almost a little bit, that's what would make me not want to share anything with my doctor, because they kind of give you that look, you can just kind of tell from their face… that would make me shut down, not tell him anything.

Both Jordan and Jasmine described how patients are very attuned to nonverbal communication of the physician, and interpret this nonverbal behavior as a sign of what the physician is thinking and feeling about the patient.

Facial expressions can both be a reaction to a patient opening up about sexual behavior, or can pre-emptively contribute to patient's perceptions of their ability broach topics about sexual behavior to their doctor. Maria talked about the importance of her doctor smiling during their communication,

> I feel like a very big [factor] is if they smile, because I think about the guy who was my primary doctor, he never smiled…And then, I'm just not even thinking about the question, and it's happened before, to the point where I just walk out of the doctor's office and I'm like, "Wait, I still forgot to tell

> him that I had this going on." And then it's just like, "Great, do I make another appointment or do I just forget about it?"

Maria attributed her physician's facial expressions to creating a barrier between herself and the physician, to the extent that she frequently missed the opportunity to raise a health concern.

Ciara talked about not only the importance of facial expressions, but also how physicians have the ability to change those facial expressions. As if speaking to a physician, Ciara said,

> If someone's telling you something, as you listen, think about what it takes to listen, why you're listening, and it will create your listening face, [make it] a little softer. It's like a processing face, it's like "Mm-hmm," not "Ahh!"

This belief that a physician can improve their use of facial expressions to make the patient more comfortable, references the potential for training to optimize this communication.

Body language. Participants also used physician body language interpret and gauge the physicians' discomfort and communication competence. Kameron described how body language can communicate whether a physician is uncomfortable,

> [If a doctor is] not acting like it's some kind of uncomfortable topic … and like this is a normal, comfortable thing to talk about … even like body language … just talking about it in a way that makes it seem uncomfortable.

Ciara talked about how a physician simply turning their chair can communicate attentiveness to patients. When asked what a physician can do to make a patient more comfortable, Ciara spoke as if talking to a physician, "If your hands are closed, you're not providing open [body language] … so if you turned your chair, 'Oh excuse me I like to face my patients.'" Ciara provided specific details about how clasping hands and facing

away from the patient can communication more openness. Maria also talked about how physicians physically turn to their notes or medical charts, physically closing off from the patient,

> [My doctor], whenever you gave him information, he … never really turned to face you, and was just closed off … he just stared at his laptop and was writing down notes. "Are you listening to me or" …

Maria echoed Ciara's statement that closed body language can create closed privacy boundaries. Lisa also described experiences with closed physician body language. When asked what a physician does that makes a patient want to shut down, she said,

> I feel like being very dismissive of everything… also like the wave off the hand has happened, and I'm like, oh my goodness, like you're literally waving me off. I've also seen slouching while writing… I think like posture, I feel like it's a good thing because if you lean into somebody like … "I'm interested what you're saying."

Lisa felt as if the doctor was waving her concerns away, and described how body language leaning toward the patient can create a sense of attentiveness.

In addition to facial expressions, posture, and proxemics, another facet of nonverbal communication involves vocalics, or various vocal properties that convey meaning. In the interviews, the phrase "tone of voice" was often used to describe certain aspects of vocalics, and similar to facial expressions and body language, were used to interpret interactions with a physician.

Tone of voice. A physician's tone of voice was described as having the potential to communicate nuanced paralinguistic meanings and foster either an open or closed privacy boundary. For example, when talking about what a physician might do to make a patient shut down, Ferni said, "Even the tone of their voice when they're trying to give you advice might belittle you sometimes." This sense of being "belittled" may result in a

recalibration of privacy rules, ultimately creating closed privacy boundary. When asked the same question about what a physician does to make a patient shut down, Miranda said, "I would say tone of voice. If you're going to sound condescending, that's gonna make me reevaluate how much I tell you… and then that could be bad for me in the end." Similar to Ferni's description of belittling, Miranda described how a tone of voice can convey condescension, creating a closed privacy boundary.

When speaking about tone of voice, Emma spoke about how a physician should maintain a calm tone of voice, in order to keep the patient calm,

> Being calm about it, not really like, "Ahh, all this is bad, this is terrible," but … even though adults know what's going on, you might have to still talk to them in a way that's not like the world's gonna end.

Jasmine also emphasized the importance of remaining calm, and spoke to the difficulty of defining the specific aspects of tone of voice that create a sense of calm. When asked what her doctor does to make her feel more comfortable, Jasmine said,

> They communicated like, I don't know how to explain it, they communicated like, when they talk it was like a soft voice and it wasn't like hard, demanding… it was calm, and pretty much, I can't explain it. I didn't feel like I needed to shut down.

In spite of Jasmine's stated difficulty in defining these vocalics, her description of a soft, undemanding manner of speaking vivifies a calm tone of voice. Lisa also described how physicians can use their tone of voice to facilitate an open privacy boundary. When asked what a physician might do to make a patient open up, Lisa said, "The tone of voice, like if they're friendly and welcoming the tonality changes."

Participants described how physician's nonverbal behavior can create a communication climate where patients feel welcomed and comfortable, or can create an environment that discourages private disclosures served as catalyst criteria for privacy

management. Physicians' ability to exert such control over the communication climate stems in part from the power they wield in the relationship with the patient. In addition to physician communication competence, participants in this study were very aware of the role of power in the communication with their physicians, and spoke about how power can shape privacy boundaries.

Power. There are various criteria that people use to decide whether to link someone else into their privacy boundary, and some of these criteria have been shown to be related to confidant status or power. Status and power are related, but there are important distinctions between the two concepts (Blader & Chen, 2012). Status refers to prestige that an individual has in the eyes of others, and is conferred through the evaluations of others (Ridgeway & Erickson, 2000). In previous research, discussion of confidant status was shown to be a factor influencing private disclosures (Brooks, 1974). For example, when interview confederates were given the title "Dr.," in comparison to the title "Mr.," participants were more likely to disclose (Brooks, 1974). In contrast, power does not emerge from the evaluations of others, and instead refers to an individual's ability to control critical resources. Further, power is particularly important in communication, and because of the potential to control resources, has implications for social justice as well (Blader & Chen, 2012). Whereas high-*status* may increase a person's attention to other's perspectives, a high-*power* individual may decrease attentiveness to other individual's perspectives and opinions (Blader & Chen, 2012).

While power (Peck & Conner, 2011) and status (Goodyear-Smith & Buetow, 2001) have both been studied in physician-patient interactions, participants in this study specifically referenced a physician's power and their ability to control a patient's access

to healthcare resources. Power in caregiver-patient privacy management has been previously explored from the perspective of the caregiver in a study explaining how nurses' power in Scottish nursing homes shaped privacy management (Petronio & Kovach, 1997). The current study provides details about the role of power in communication from the view of the patient.

All of the participants reported that the physician has more power than the patient, although a few argued that this should not be the case. Lisa remarked how a power difference between the physician and the patient can influence communication, and when asked what a physician can do to help a patient open up, she said, "just not being condescending, that could just be… just because of the power dynamic." Other participants also remarked on the complicated power dynamic between physicians and patients.

When asked to describe the power dynamic between physicians and patients, Alina said,

> That's kind of hard one, because you know the doctor should have more power. But I feel like as a patient, you have the power because they have to focus on you, an individual, because they're helping you. But then the doctor has more power because they need to get the medication. It's kind of hard to decide who has power, because if you're a patient, if you don't cooperate, you're kind of screwed. So, they are in power.

In this statement, Alina described how both the patient and the physician each hold their own kind of power in the interaction, based on what the physician needs (e.g. information from the patient), and what the patient needs (e.g. medication and treatment).

Ferni explained her beliefs regarding the reason why physicians may have more power,

> You're going to them for their information, their knowledge to help you. They went to, like, so much school, and they can help you. And you kinda just, like, listen to whatever they have to say and you try to listen. And then sometimes you could be intimidated and not want to say stuff.

It is an unfortunate paradox that the education and training that give the physician the abilities to help a patient may intimidate the patient into silence.

Thabisa talked about how a doctor's power can create an aura of intimidation, and create a barrier between the doctor and the patient,

> I don't see a doctor as "someone," I see them as just a doctor. And it's bad, but I don't see them as somebody that's like at the grocery store, doing [mundane things]. I see them as like this is it, [practicing medicine is] all they do 24/7. But I feel like they have more power. If they choose not to listen to what you're saying, or they don't believe you, their opinion … determines how they diagnose you, how they treat you. And so … you're just telling them what you think, but at the end of the day, they're making the decision.

In this statement, Thabisa described how the physician's ability to make a diagnosis or create a treatment plan makes the patient vulnerable to their decisions. Ciara also described how a physician's power can shape communication, and how power can be used in both positive and negative ways,

> Power . . . we don't really talk about it much, because power has such a negative connotation, right? … Everyone needs to understand that it's not just about the power that you hold, it's is about what you do with the power that you have. So, what are we doing with it? How we distributing it? Are you just walking around here because you're the damn doctor, you're the you're the highest surgeon? Motherfucker we *know* you're the highest surgeon. We know.

Later, Ciara expanded a bit more about the importance of power in communication with a doctor,

> Listen, a wise man told me, "The person that asks the question controls the conversation" … Because if [the patient's] asking the questions, they're controlling the conversation, don't try to take that from them because

> you're the physician, allow them to exercise the power that they have in their vulnerable state.

Ciara's specific reference to a physician's ability to control the communication confirms the importance of power in private disclosures. She explained that physicians have an opportunity to create a space where patients feel they can open up and ask questions. Further, even though the patient's power in the interaction is limited, a patient's ability to ask questions can create a sense of control and reduce the risks associated with private disclosures. In addition to power, issues of limited time were woven throughout the participant's responses and created both a sense of empathy for the physician and served as a catalyst criterion for closing a privacy boundary.

Limited time as a catalyst for a closed privacy boundary. As demonstrated in previous studies on privacy management, privacy rules can be driven by limited time (Ebersole & Hernandez, 2016; Petronio, 2002). A physicians' limited time to communicate with patients has been demonstrated in research (Dugdale, Epstein, & Pantilat, 1999; Gross, Zyzanski, Borawski, Cebul, & Stange, 1998; Temple-Smith, Hammond, Pyett, & Presswell, 1996; Verhoeven et al., 2003), and participants in this study were also aware of this specific challenge in delivering health care. In the case of limited time, some participants were focused on the needs of the physician and exhibited an empathetic response, wanting to preserve the physician's time. Other participants were focused on their own needs regarding time with the physician.

Closed privacy boundaries focusing on the physician's time. Participants in this study showed a strong awareness of physician's difficulty managing time while seeing patients. In addition to this awareness, patients described a sense of empathy toward their physician regarding their limited time for seeing patients. The patient's empathetic

response and a resulting closed privacy boundary were catalyzed by physician behaviors signaling a limited sense of time (e.g. the physician didn't sit down, didn't greet the patient, or obviously skipped questions on a checklist).

As reflected in earlier themes, participants often mimed the physician using a checklist, skipping questions, or answering their own questions as a result of limited time. Participants also expressed understanding of a doctor's heavy workload. Although she was generally negative about her experiences with doctors, Thabisa did have a sense of empathy about their limited time. When asked whether limited time would encourage her to open up more or less, Thabisa said,

> [I would tell them] less, because then I would pick out the important parts of what I need to tell them, just because I feel like they probably have somewhere else to be, so let me just tell them "this, this, and this." And then by that, they should get an idea of what I'm going through.

Thabisa described self-editing information about her concerns about sexual behavior as a result of limited time. However, providing incomplete information can preclude an accurate diagnosis, and may leave Thabisa without answers to questions she may have. Juana also expressed empathy for her physician, saying,

> [Time is] a hard thing to try to win because that's their job. And logically, I want them to see as many people as possible, to help as many people as possible. But at the same time, I'm person who likes conversation and I'd rather sit there and…talk. So, I would want to have a conversation to ease more into it, and that was probably why I have issue with not feeling comfortable, because I just always kind of feel rushed, but I think that's a hard battle to win. You've got to balance things out, and you can't always have time for everybody. You wanna help everybody.

When asked whether she had empathy for a physician's limited time, Ciara said,

> Hell yeah! Because day after day, hour after hour, minute after minute, you coming in, seeing people, so I can understand… like a piece of it is because you don't want to be so bogged down and you probably couldn't

> perform at your best … but you still need to uphold some type of regard for who and what we're dealing with.

Ciara referred to the balance between "performing at your best" by reaching as many patients as possible, and also focusing on the individual patient in the room. Monique also referenced this balance, stating that while she had empathy for a doctor's limited time, it was important for a physician to use their power to help patients,

> I could understand that they're working with many patients throughout their day, but it is important just to give everybody a certain amount of time, respect…if you're a doctor, you're somebody in a position with power, you're somebody in a position with knowledge. So, [as a patient], I would like to spend time with you and feel comfortable with you. So, if they did spend time, if they didn't seem to be dismissive with their patients, that would probably help as well.

Monique statement reiterates the fact that patients want to feel comfortable opening up to their doctor, but the behavior of the physician often establishes a level of comfort.

Alina also described a sense of empathy for her doctor when speaking about her perceptions of occasions when she felt there was limited time. When asked what behaviors signaled a lack of time, Alina said,

> Probably just the way they talk. You can see, you can feel when a person has an attitude or in a bad mood. I mean things happen in life. When you get to work, you're probably stressed out, and you just take it out on the patient or something if they've made you mad. And it's understandable, but …

Sabrina also described her concerns about doctors taking enough time with their patients, particularly in an effort to ask the patients questions about their life,

> I think a part of that is because they are… I know doctors have more than one patient that are waiting on them. So, you don't always have to… they try their best but it's also, like medical humanities, how you treat your patients outside of them as being patients, and I think just like even just taking the time out of the day to just asked them how the day is going, or like just ask them about their life so far. You know, take a breather two, just trying to relax.

It's notable that Sabrina used the phrase "medical humanities" to describe her perceptions of physician-patient communication and time and serves as yet another example of the heightened awareness of these participants about issues in healthcare. It is unclear whether this awareness was a result of the sample, or part of a broader trend of awareness in this area.

Finally, underlying this sense of empathy for a physician's limited time was a desire for the opportunity to take the time to talk to their doctor. For example, while Ferni acknowledged the large number of patients the doctor must see, she also asserted her needs a patient as well. As if speaking to a doctor, she said, "I know it's your job, and you have, like, 'this many patients' to get through, but like, I'm also a patient, individually, and you should also pay attention to me." The participant's empathetic responses to a physician's limited time had important consequences of privacy boundary management. The sense that there was limited time was also focused on the patient's own need for time with the physician and was often described as a catalyst for a closed privacy boundary.

Closed privacy boundaries focusing on the patient's time. A sense of limited time often led to participants preemptively closing a privacy boundary. When asked if a sense of limited time would make her open up more or less, Miranda said,

> I would probably say less, just because I wouldn't want to bring up a big topic, and then be cut short… I would rather just like save it 'til next time and then possibly… you know, something could go wrong in the meantime, or it could be worse by then, too late…

In this quotation, Miranda described limiting her communication with the doctor in anticipation that the conversation would be cut short, and also the potential health

consequences of closing this privacy boundary. When asked how a patient might feel in response to limited time, Alina said,

> That they don't really need to share anything with them, because they don't show interest in them. So, they'll be like, "You don't feel interested in me. Okay, I'm not gonna share the information with you then."

Alina believed that a sense of being rushed also meant that the physician was not interested in her, and as a result, she closed a privacy boundary. Another participant, Ferni, described physician's behaviors that signaled limited time,

> Talking quickly or trying to get through the conversation quickly, skipping steps and getting to the point of "what's wrong." I remember there was a situation where there wasn't a lot of doctors, I guess, and I was in the office for an hour, waiting for the doctor to come see me. It's like *I* was here on time, but they're really going back and forth and they would peek in and be like, "I'll be right with you." So, they're gonna go through everybody [snaps fingers] and not care… like it was a bad day to come to the doctor today because they're not gonna pay attention to me, because … They've already decided in their heads that they have to get through me, just to keep going. So, why would I talk?

Ferni's belief that her physician "had already decided in their heads" they needed to get to the next patient made her feel that she wouldn't open up about her concerns.

Layla believed that it was widely known that physicians have limited time and that this knowledge can shape patient communication,

> If you feel like you're wasting the doctor's time, or the doctor views you as a 20-minute time slot, then you're not going to want to talk about anything…And of course, doctors are busy people. That's not a secret to anybody. But I've been with doctors who make me feel like I have all the time in the world, and I've been with doctors who make feel like I'm being a huge inconvenience by scheduling an appointment. I've had [an experience] where I was talking about something, and I tend to ramble… and so I was talking about a problem I was having and I was like, "Oh, it actually kind of relates [to this other thing] . . . And they were like "No. Answer the question." I was going off on a little bit of a tangent, but I was still going to get back to the thing that I was talking about. I don't like that. Let somebody talk.

In this statement, Layla also emphasized that the experience of time is in part based on the physician's behavior, and they have the ability to make the conversation feel like an inconvenience, or "all the time in the world."

Maria talked about how her neurologist explicitly asked her if she was satisfied with how they spent the time, but that she was confused about how to respond,

> He literally reads off . . . I don't know if he's supposed to read it off, but at the end, he reads it off right away. I'll go in, he'll ask me how I'm feeling, if I'm taking my medication, if anything new is going on. I'll tell him no, and then he'll be like, "Okay, it looks like you're good." He'll read off, "Do you feel like you're satisfied?" Literally word for word. "Do you feel that you have been satisfied?" These are not his words at all and he's just reading them off. And he's like, "Do you feel that I've spent enough time with you?" And I just say yes because if I told him no, what else we're going to talk about? . . . I'm literally in that office for no more than five minutes… [but] with my OBGYN, I'm with her for a long enough time. I feel like she answers all my questions.

For Maria, although the neurologist explicitly asked if she felt she had enough time, the fact that he was reading off the question made her feel that it was disingenuous. In contrast, she felt that her OBGYN doctor made her feel like there was enough time to ask questions.

Some participants expressed empathy for a physician's time pressures in communicating with patients, and this empathy was often framed as catalyst for preserving the doctor's time, and not opening up about their health concerns. Other participants felt that a physician acting as if there was limited time was a signal that they were not interested in the patient's information, particularly private information about their health concerns, and their social history. It is important to note that participants felt that limited time precluded disclosures about a social history, which is an integral to

taking a sexual history and gaining a full understanding of the patient's needs and circumstances (Ende, Rockwell, & Glasgow, 1984).

These themes regarding privacy rule development showed that patients must make decisions about privacy management while negotiating dialectical tensions including openness/closedness, conventionality/uniqueness, and emotions/objectivity.

Dialectical Tensions

In addition to these criteria for developing privacy rules, dialectical tensions underpinned many of the discussions of privacy management. Dialectical tensions refer to two competing and unresolved tensions which are constantly in flux, for example, stability and change (Baxter & Montgomery, 1996). Central to CPM theory is the concept of dialectical tensions (Petronio, 2002). Petronio (2002) explains that privacy/disclosure is a primary dialectical tension, and privacy issues often interact with secondary dialectical tensions. In the current study, privacy rules were often driven by certain dialectical tensions. Participants in this study described three themes that revealed these dialectical tensions in communication between physician and patient.

First, the openness/closedness dialectic was extant in participant's desire to conceal private information from their physician without being labeled as a "liar." For many participants, they did not classify concealment as "lies," and instead viewed concealment as controlling private information that they owned. Second, participants described a conventionality/uniqueness dialectic. Participants expressed a desire to be seen as "normal" and conforming to societal expectations, while simultaneously feeling like a unique individual who receives personalized treatment from a physician. Finally, participants described a dialectic of emotions/objectivity, describing the tension between

wanting a physician to harness emotions and show empathy, while simultaneously objectively assessing the needs of the patient. Each of these themes demonstrate the vacillation between two competing tensions in the communication between doctor and patient.

Openness/closedness. Participants demonstrated an interesting dialectical tension of openness/closedness when discussing "truth-telling" in the physician-patient encounter. Much of the medical literature treats patient communication with a "truth/lies" binary, asserting that concealing or partially concealing private information is a lie (Iezzoni et al., 2012; Tuckett, 2004). However, when describing their own private information, patients often added complexity to the concept of truth and lies. For example, for these participants, avoiding discussion of some aspects of a sexual history was not considered to be a lie. Instead, the strategy was framed as topic avoidance, not lying.

This finding extends research that shows that in certain circumstances, disclosers often do not consider a closed boundary around private information about sexual behavior to be a lie (Nichols, 2012). One participant told a story when her closed privacy boundary was interpreted as a lie,

> When I was young I was taken advantage of, and I ended up getting an STI. I was really young at the time, so I couldn't go the doctors because I didn't want my parents to know, and when I turned eighteen I went and got it cured. I'm the type of person that's just like, "Let's forget about this, act like it never happened." So, when I first went to my gynecologist for the first time, the nurse asked me if I ever had and STI, and I'm like the type of person, like, "It never happened." I said "No," and then she gives me, like this look like "don't lie to me," and made me feel dumb. But like, I don't want to say "Yes" because maybe she'd think I whored around, but really, I was just taken advantage of. And so, I don't want to say [I had an STI], but after that experience, it's been, like hard to connect with her

> because I felt really judged in that instance… that was a really hard time in my life…

For this participant, a painful experience in her life was considered to be private information, to the extent that she tried to hide the information even from herself, by pretending the experience didn't happen. When the nurse labeled her omission as a lie, the participant felt offended, and believed that her circumstances were more complicated than simply "the truth or a lie." Kameron also echoed some of these points, reflecting on how patients open a privacy boundary to the extent that they feel comfortable. When asked to define honesty, Kameron said,

> [Honesty is] revealing as much as you can without, um, without uh, I guess harming yourself. Yeah. Or making yourself feel super uncomfortable, which I know sometimes you have to be a little… maybe sometimes have to be a little uncomfortable in order to get the help you need.

Kameron articulated one aspect of the tension between openness and closedness, the need to be open to receive care, while also protecting themselves from severe discomfort.

Another participant, Layla, spoke about her perspective on disclosing the fact that she had recently become sexually active,

> I actually for the first time recently, I had never told a doctor or told anybody that I have been sexually active before . . . I mean, I never lied about it, but I just never told them because they just always automatically put "No." So, it was just like, and I never told them "Hey wait, this has changed." I just didn't feel the need to do that. Because I have a UTI and they were like, are you sexually active? And I was like, "I don't know what that actually means, but yes." So that was the first time I had ever just told a doctor.

In Layla's past experiences, the physician's strategy of answering their own questions subverted her response about sexual activity. However, Layla's statement, "I never lied about it, but I never told them …" showed that she believed that if she didn't have an

opportunity to answer the question, she wasn't lying. Layla had some experiences working in drug rehabilitation, and at times used those experiences working with healthcare professionals as a reference point for describing doctor patient communication. Layla described some of the language used in her workplace as a substance abuse counsellor that related to taking a medical history from a patient,

> Where I work, they call it a "poor historian" … when somebody's not being totally forthcoming or just not being clear on things. So that's like "ding, ding, ding" of like, mm-hmm, this patient has lied or doesn't talk about things or whatever. I mean, there's really no such thing as complete honesty. You really can't be completely honest in a situation… also it's just like doctors, I don't know, they just really have this very skewed outlook on patients like, "Why wouldn't they tell me that?" And it's like, okay, well you got to think about how you're coming at them. Think about that.

For Layla, a patient's disclosure of some aspects of their medical history is not black and white, and is shaped by the behavior of the physician. Another participant, Katie, talked about her perspective on lying, and the consequences of fully opening up to her doctor,

> They can have a record of that. I'm scared that if I want to apply for another job, even though [they say it's confidential], I'm not sure how confidential it would be. So that's why I'm just not trying to say too many words to my doctor because it's going to stay on my permanent records … So, I was worried that a future employer or insurance would find out … and then that they would do something about that. So, I just would, I lie. Yeah, basically, probably, I'm not lying but I'm just not talking about it, hide it . . .

In Katie's description of her concerns about confidentiality, she characterized her privacy management as "probably I'm not lying, but I'm just not talking about it, hide it… ."

Julie spoke about the dialectical tension of truth and lies in a similar way, stating,

> For a lot of clinics, you fill in what your symptoms are beforehand, like you fill that paperwork out, like, "These are my symptoms," and then some of the questions, at least for me, you're kind of like well "I don't know how to answer that," you kind of like answer one way, but it's not completely true, you know. You're just like "Ok I'll check this [box]," but

> like it needs more explaining. And so then you submit the paperwork, and what happened at the [State University] clinic is like you get in there and they're like "okay you have x y and z, here's what you should do, BYE" But well I didn't get to explain why it's particularly weird, you know, yeah and so it's just like I didn't really get to tell you the accurate picture in my opinion. So, they're kind of diagnosing what they just constructed in their head, instead of what I actually said. And I know they're going off the form which I filled out, but at the same time… yeah so, it's like I feel like I can add and give you more of a better read, but they just don't seem to care.

In Julie's statement, she described how the questions on an intake require more context in order for a physician to gain a complete understanding of the patient.

Participants' statements challenged the truth and lies binary, and complicate the dominant perspective of a patient lying about their sexual history. By revealing the complexities of privacy management in patients, the theory of CPM can allow physicians to think about the privacy boundary and their own role in creating an environment conducive to opening a privacy boundary, in contrast to the need to extract the truth from a patient.

Conventionality/uniqueness. At times, people face a tension between the need to feel that they're part of a larger group and conform to the group's expectations, and the need to feel like a unique individual (Baxter & Erbert, 1999; Braithwaite & Baxter, 1995; Prentice, 2009). Often, the tension between these needs arise through communication. In this study, participants described the need to feel that their private disclosures about sexual behavior were not deviating from the norm, while also feeling that a physician viewed them as a complex individual with a unique set of circumstances. When asked how she felt about the phrase "I ask all my patients this," one participant, Lisa articulated fears of the about feeling "abnormal" particularly well,

> Another thing [about doctor-patient communication] is [the doctor] making someone feel like the "other." So, there's, like the majority, and then there's the minority, which is like the "other." And that makes you feel not part of "the group" and, like, "Something's wrong with me, that must be what's happening?"

Several other participants described the conventionality/uniqueness tension present in the physicians' often-used phrase "I ask all my patients this." When asked whether she would prefer a physician initiate communication about sexual behavior by saying, "I ask all my patients this," Ferni explained how this phrase might help normalize discussion of sexual behavior,

> Yeah, because if not … you might feel singled out like, "Oh, why is the doctor asking me about my sexual health? Like, why me?" Yeah. You're so like, "I ask all my patients about this," not in a way like single them out like "I feel like *you* need to talk about sexual health," … Yeah, kind of like, well, "I ask everyone this, so you're just like everyone else." But then it's like "*Your* health is important to me, so I'm asking this for *you*." But the way that the phrasing it's like, well, it's just another question to get out of the way. Yeah, so it's like it's just… the wording is really hard because it's good, it's like coming from good intention and like it's not bad, they really want to help you, but, yeah, it's just hard to get it out.

Ferni's statement reveals an interesting paradox of attempting to use language that treats the patient as an individual, while also addressing the need to conform to social expectations about communication about sexual behavior.

Kameron reacted to the transition phrase "I ask all my patient this," by saying, "I think that's good, because they aren't trying to make it a personal thing. You know, if it's something they ask everybody, it makes it more… it makes it seem more objective, I guess. And non-personal."

Maria described how a physician explicitly labeling an experience as normal could help safeguard her against being judged,

> I guess just feeling, other than comfortable, knowing that I'm not the only one going through this. So, if they're talking to me about it, … maybe starting with like, "Oh well, I know people your age are going through this, and how are you feeling about it?" And, just a good lead way to open up but yet still be comfortable with it.

Another participant, Juana, talked about how it can be difficult to give personalized treatment while making a patient feel "normal." When asked about her opinion on the phrase "I ask all my patients this," Juana said,

> Things like that can cause an issue, it's weird. We live in a society that everybody wants to be the same. But everybody also wants to be like, completely different and be their own [person]. And I think that's really hard to do.

Mary also talked about how a physician can make a patient feel "normal,"

> I think it would be nice just because… But I don't want them to lie. I want them to actually be like "oh I actually do ask all my patients this." Just because it's kind of like "this is normal"… because we like "normal." We don't like things out of the ordinary … Normal is just easy and everyone wants the easy way. So, yeah. I want them to make me feel comfortable and like I'm normal in a way…

Given the widespread societal taboos regarding sexual behavior and the discussion of sexual behavior, it is unsurprising that participants would want to feel as if the discussion was normal in that particular context, particularly as female patients seeking sexual healthcare.

Emotions/objectivity. Many participants were aware of how physicians' thoughts shaped their perceptions and communication with patients. Participants framed physicians' communication about sexual behavior as a tension between harnessing the use of emotions and using objectivity to accurately diagnose and treat the patient. For example, Mary described how she wanted a physician to act professional, and yet harness their emotions to be more human and less robotic,

> I personally like somebody that does not have monotone. Because if you're telling them this awful story of how you've had all these bad experiences with doctors and they're like, "Oh, I'm so sorry. I don't know what to do." If they're like that, then obviously you're just like, "Do you care? Are you just a robot?" I think that is one thing. Just not being the robot. Having those characteristics of just showing a little empathy but still keeping it professional. [Not] like, I'm sobbing and you're sobbing. I know in some cases it would be hard, but it's that type of thing. Just keeping it professional in certain ways, but still showing me that you care and you want to make it better for me.

Mary described how a physician must be able to access their emotions in order to show their compassion for the patient, while also remaining professional.

Ciara referenced how the training of a physician can create difficulties in communication between doctors and patients,

> [Doctors] are programmed… which I understand you like, can't be emotional, I'm not suggesting I want them to be mushy, but I am saying, like, whatever [the training] processes is, it needs some tweaking … They need some softening up, they need … there is some changes that need to happen there.

Layla talked about how physicians must find a delicate balance between remaining objective and accessing their emotions to care for patients,

> There's just a lot of like personal biases that doctors really need to get over… just like doctors doing that nice little tightrope of just walking in between like, "Yes, I'm objective, I'm remaining free from my personal biases, but also, I have the emotional capacity as a human being to respect you and to make you feel like you're valid." Even if it's the dumbest thing you've ever heard…I just feel like a lot of times that nice little balance needs to exist in order for there to be a productive relationship.

While "objectivity" is often heralded as the most important part of physician decision-making (Coulehan & Williams, 2003; Halpern, 2007), participants also emphasized the importance of harnessing emotions to care for patients. Further, despite how they are often framed in medical education (Coulehan & Williams, 2003; Halpern, 2007), emotions and objectivity do not always have to be in tension. For example, emotions can

sensitize physicians to important social issues for the patient, while being integrated with the objectivity needed for clinical decision-making (Graber & Mitcham, 2004; Halpern, 2007).

Conclusion

Participants' interview responses revealed themes of privacy management about sexual behavior with physicians. These themes included factors that shape privacy rules, such as societal, cultural, and gender-based rules, the benefits and risks of private disclosures, physician communication competence, power, and the role of time in privacy management. Finally, extant in the participants' interview responses were dialectical tensions illustrating the complex push and pull of patients' needs and physicians' needs in physician-patient communication about sexual behavior. The following chapter will discuss the theoretical and practical implications of the results of this study.

Chapter 5: Discussion

This dissertation study explores how college students develop rules for privacy management about sexual behavior. The semi-structured interview format allowed for the collection of rich, in-depth data about college women's perceptions of communication with physicians. The results demonstrate how college students sought out communication with a physician to discuss some of these topics, and vividly illustrate the dynamic processes of privacy rule development. In the participants responses, privacy management rule development and recalibration were iterative; in other words, privacy rule development was both an antecedent and consequence of privacy management. These findings have both theoretical and practical implications, as well as limitations, and provide suggestions for future directions of study.

Many participants expressed a sense of hope regarding communication with their doctors, yearning for the opportunity to open up about various topics regarding sexual behavior. Participants saw significant value in the ability to make decisions about their health with their doctor and wanted to build a relationship with their doctor over time. However, not all discussions of physician-patient communication were positive. For example, some participants described negative experiences communicating with physicians about sexual assault. When patients are afraid of a breach of confidentiality or negative judgment from their doctor, this fear can create a closed privacy boundary, subverting the opportunity to find counselling and testing for STIs. Communication about sexual behavior inherently puts the patient in a vulnerable position, and these types of negative experiences exacerbate patients' fears about opening up about sexual behavior. In addition to explanations of privacy rule development, woven throughout participant

responses were dialectical tensions which intensify the complexity of doctor-patient relationships. The findings of this study provide important details about college student's privacy rule development and have several theoretical implications for the theory of communication privacy management, as well as understandings of implicit bias.

Theoretical Implications

Advancing communication privacy management theory. This study builds on the theory of Communication Privacy Management, first developed by Petronio (2002). First, this study demonstrates the dynamic processes of privacy management. The results illustrate how privacy rule development is often an ongoing practice, integrating perceptions of physicians' communication into patients' privacy management. These results show that for these participants, the phrase "taking a sexual history" (which suggests a discrete and unidirectional transfer of communication (Bilney & d'Ardenne, 2001) did not capture their experience with deciding to open up about sexual behavior.

Specifically, individuals in this study described both drawing from stable, core rule criteria (e.g. societal privacy rules), as well as integrating triggered catalyst rule criteria over time (e.g. assessing a physician's communication competence to inform privacy rules). Participants described how past experiences with managing private information with physicians served at catalyst criteria, and used these experiences as input for future decisions about revealing and concealing private information about sexual behavior. This pattern of privacy management echoed previous findings in the area of sorority women's privacy management about sexual behavior (Hernandez, 2018b). As suggested by this earlier study, the balance of catalyst and core criteria may be indicative of college women's time in the lifespan. For example, these participant's

experiences stand in contrast to the adolescent experience of living at home where core criteria for privacy management are dominant (Ebersole & Hernandez, 2016). For college students, social expectations for privacy management about sexual behavior may be shifting, catalyzed by the need to seek healthcare as an adult. This need to seek healthcare for the first time also brings the opportunity to make autonomous decisions about privacy management regarding sexual topics, rather than rely on their parents' expectations. This research echoes previous research showing that privacy rules about a single topic can shift over time (Bute & Vik, 2010).

The results of this study also reflect prior research demonstrating that patients will conceal or only share partial information about their sexual practices (Bilney & d'Ardenne, 2001; Lewis et al., 2011; Rose et al., 2009). Building on previous research in this area, the participants in this study provide a more rich and detailed explanation of why patients choose to share only partial information, due to perceptions of power and physician communication competence, and adds to this research by interpreting this phenomenon through the lens of CPM. Another contribution of this dissertation study is the further exploration of societal privacy rules.

Participants emphasized how the social expectations surrounding topics of sexual behavior informed core privacy rule development. Recently, research has begun to explore how societal expectations can shape privacy rules (Bute et al., 2017), and participants in this study also attributed some of their privacy rules to the societal expectations that can shape communication between doctors and patients. Discussions of sexual behavior are generally considered to be taboo in society, and these broader societal expectations often create a closed privacy boundary around communication about sexual

behavior. More specifically, participants described how socializing forces such as education systems create a cone of silence around issues of sexual behavior. On a different level, participants also described how cultural influences shape communication about sexual behavior (e.g. a physician from a conservative culture answering their own question about the possibility of a patient being pregnant). The themes of societal and cultural privacy rules offer a theory-based explanation for why some patients and physicians experience discomfort with interpersonal communication about sexual behavior and explain how broader forces of socialization shape interpersonal communication.

Participants also described how the perceived risks of opening a privacy boundary shaped privacy rule development. These risks included physician bias, judgment, delegitimization, and confidentiality breaches. Physician bias toward patients has been well-documented in research (Van Ryn & Fu, 2003). The current research study demonstrates that in addition to being a topic of interest for the scholarly community, this phenomenon has also become part of patient's perceptions of their doctors, and consequently, communication with their doctors. Participants were concerned that physicians may be biased toward patients who are part of minority social groups, such as race, age, and immigration status. In addition to these minority social groups, there were also concerns about physician bias based on the patient's age, stemming from experiences with physicians treating a patient differently based on the fact that the patient is a young woman. These fears about physician implicit bias add another factor that shapes privacy rule development, introducing one of the first applications of a critical

lens in discussion of privacy management. This application of a critical perspective is further discussed in a later section of this discussion.

Related to fears of physician bias were participants' concerns about physicians treating a patient differently based on their moral judgment of the patient's sexual behavior, such as disapproval of having unprotected sex. These concerns about facing judgment from others echoes previous research on privacy management about sexual behavior (Hernandez, 2018b). For sensitive issues such as sexual behavior, concerns about physician judgment have the potential to lead to a pre-emptively closed privacy boundary. This closed privacy boundary may be detrimental to the patient, who wants to receive advice and treatment about sexual behavior. In addition to harming the patient, this closed boundary is undesirable for the physician, who wants to have a complete social history of the patient to provide the best care possible and preserve the relationship between the doctor and the patient.

These female patients were also very concerned about being delegitimized by their doctor. Fears about their health concerns and pain being brushed off led participants to pre-emptively close a privacy boundary, or re-calibrate privacy boundaries. Some participants believed that once they opened up about their sexual health symptoms or concerns, their private disclosures would be immediately disregarded as irrelevant or overblown. Generally, women hold lower social power and status regarding sexual behavior (Gómez & Marin, 1996; S. Moore & Rosenthal, 1992; Pulerwitz et al., 2002; Wulfert & Wan, 1993). As a result, they may fear the embarrassment of being dismissed by their physician. As a self-protective measure, participants described guarding a closed privacy boundary, and not opening up about sexual behavior. These descriptions of

delegitimization illustrate the dynamic processes of privacy management; participants developed privacy rules either because they believed that their concerns *would* be brushed off, or reactively closed a boundary after feeling they *already had* been brushed off.

Finally, participants in this study described the importance of interpreting physician's communication to develop privacy rules regarding sexual behavior. For these women, privacy rules were described as being triggered by perceptions of physician's communication competence. Participants were keenly aware of the patterns of communication that physicians use with patients, and were aware of how physicians make decisions about patient care. Participants used this knowledge about physician's communication competence to inform the development of privacy rules by interpreting how physicians use checklists and how they view the humanity of the patient. Additionally, physician's verbal communication such as tone of voice and answering their own questions shaped privacy management. This verbal communication from physicians often signaled physician discomfort leading to a closed privacy boundary for the patient. For example, a physician asking and answering questions about sexual behavior implied that the physician was uncomfortable with hearing the patient's response, and wanted to move quickly through the questions. These results show the dynamic nature of privacy management, and how core and catalyst criteria come to bear on patients' privacy management. For example, patients may initially use core privacy rules for decision-making about opening up about sexual behavior, and then spontaneously develop privacy rules as a reaction to conversational dynamics.

Similar to verbal behaviors, participants also explained that nonverbal behaviors signaled physician's discomfort. The results are similar to several studies that have explored how non-verbal behaviors can create separate privacy boundaries between both the confidant and the discloser. For example, Afifi (2003) described how teenagers in step-families would avoid eye contact, looking past their parent to signal a closed privacy boundary, and in response, step-parents would also withdraw from communication. Participants in the current study also described how they were aware of physicians' nonverbal behaviors and discomfort that created a closed privacy boundary for the patient. These data further explain why these patterns of withdrawal occur by emphasizing the patient's construal of physician discomfort, and the patient's communicative reaction to the discomfort. Consequently, the results of this study further elucidate the interpreted relational *meaning* of nonverbal behaviors, explaining the iterative processes of boundary management and recalibration. Nonverbal communication was also implicated as revealing a sense of limited time surrounding doctor-patient communication.

While patients are generally aware of a physician's limited time (Dugdale et al., 1999; Gross et al., 1998), in this study, motivations for closing a privacy boundary were often driven specifically by empathy for a physician's time. This empathy may be related to the fact that the participants were female; female adolescents are generally more empathetic than male adolescents (Mestre, Samper, Frías, & Tur, 2009). The findings of the dissertation study show that the participants described being empathetic toward a doctor's limited time to care for each patient, and pre-emptively closing a privacy boundary to preserve the doctor's time. Building on previous research on *physician*

empathy and privacy management (Petronio et al., 2012), this finding is one of the first descriptions of how *patient empathy* for the physician-confidant can drive the opening or closing of a boundary. Finally, many of these criteria for privacy rule development show the iterative process of deciding whether to open up or shut down about sexual behavior.

Previous studies exploring core and catalyst rule criteria have illustrated how privacy boundaries are opened or closed based on catalyst criteria that trigger a privacy boundary change, or stable, core criteria that determine privacy rules (Child & Starcher, 2016; Ebersole & Hernandez, 2016; Hernandez, 2018b; Petronio, 2013; S. A. Smith & Brunner, 2017). This study adds descriptions of how certain catalyst criteria (e.g. anticipating bias or experiencing a sense of limited time) are driven by interpersonal communication factors. In addition to these advances in CPM theory, this study contributes to the development of the theory by integrating some aspects of critical scholarship into the interpretation of privacy rules regarding sexual behavior.

Critical issues in CPM. The results of this study answer a call for more critical scholarship exploring the tenets of CPM (Baxter & Sahlstein, 2000). By making explicit issues of implicit bias and power, the participants in this study showed how communication can perpetuate health inequities. This critical scholarship is particularly important in the context of the rise of evidence-based medicine.

Evidence-based medicine refers to the process of applying scientific research about groups (particularly meta-analyses) to decision-making about individual patients. It has been argued that there are six potential biases emerging as a result of evidence-based medicine. These biases include “limited patient input to research design, low status given to experience in the hierarchy of evidence, a tendency to conflate patient-centered

consulting with use of decision tools; insufficient attention to power imbalances that suppress the patient's voice, over-emphasis on the clinical consultation, and focus on people who seek and obtain care (rather than the hidden denominator of those that do not seek or cannot access care)" (Greenhalgh, Snow, Ryan, Rees, & Salisbury, 2015, p. 1).

It's noteworthy that participants in this study described experiencing several of these biases of evidence-based medicine. Multiple participants spoke to their perceptions of a physician making assumptions about their health based on only one piece of evidence, without considering other aspects of their experience. Participants also described how their hopes for communication with physicians go beyond being included in decisions about tests and treatments, and instead focusing on "humanistic aspects of the consultation (empathy, compassion, the therapeutic alliance)" (Greenhalgh et al., 2015, p. 3). These findings also explicitly address issues of power in the physician-patient relationship, and how power shapes communication between doctors and patients.

In a discussion of physician power and communication Nimmon & Stenfors-Hayes (2016) showed that physicians have mixed perceptions of the role of power in doctor-patient communication. Physicians across this study held different views of power; some believed that that physician power was waning, or believed that power was irrelevant in physician-patient communication. The study also found that physicians were generally surprised to be asked about power in the physician-patient relationship, illustrating the issues of power may not be at the forefront of their consciousness in communication with patients. Women generally face more struggles to exert the power to influence others (Carli, 1999). As a result, the female patients in this dissertation study may have been generally more aware of issues of power than male patients. The current

study adds to understanding of female patient's perceptions of power in the physician-patient relationship by showing the ways that perceptions of power can influence private disclosures.

In the results of the current study, power in physician-patient communication was important in several ways. First, the female participants' interpretation of physicians' communicative behavior was part of an effort to glean the physician's true feelings about the patient. While interpreting other's true feelings may be generally important in interpersonal communication, this desire to learn the physician's true feelings is likely intensified by patients having a sense of less power in the interaction (Hall et al., 1995). Goodyear-Smith & Buetow (2001) point out that both doctors and patient need power in their communication, but that power can be misused. In this study, it was suggested that empowerment of both doctor and patient is most possible in when issues of power are made explicit and acknowledged by both doctors and patients (Goodyear-Smith & Buetow, 2001). In addition to issues of power, implicit biases have also been linked to the advent of evidence-based medicine (Greenhalgh et al., 2015).

Statements about physician implicit bias toward patients were present throughout the responses of the participants. These beliefs about physician bias have been supported by research in this area. Research shows that physician implicit bias can impact patient care along the lines of race, gender, older age, and sexual orientation (Van Ryn & Fu, 2003). For example, the potential for a physician to treat a patient differently based social groups has been established by studies showing that people, including medical professionals, assume individuals who are Black experience less pain (Trawalter, Hoffman, & Waytz, 2012), and that physicians significantly underestimate pain in

patients who are Black (Staton et al., 2007). In addition to these beliefs about patients' pain, a study of Caucasian's reactions to observed pain revealed that Caucasians felt significantly less empathy for Black patients whose skin was pierced (Forgiarini, Gallucci, & Maravita, 2011). These biases also apply in the area of sexual behavior; almost two-thirds of physicians surveyed were averse to care for patients who were sex workers or were gay or lesbian (Khan et al., 2008). The results of the current study show that in addition to evidence that physicians hold implicit biases against patients, patients are also aware of these biases, and consequently withhold private information about sexual behavior. The results of this study show how biases can influence the processes of private disclosures, demonstrating another way that disempowered groups are further disempowered through communication.

These data also add to the list of social groups who may experience physician implicit biases against certain groups. Prior research has established physician bias against elderly patients (Madan, Aliabadi-Wahle, & Beech, 2001; Madan, Cooper, Gratzer, & Beech, 2006; Reuben, Fullerton, Tschann, & Croughan-Minihane, 1995; Uncapher & Areán, 2000), but has yet to be demonstrated with female patients who are young. Participants in this study showed that they anticipated potentially experiencing bias from a physician because of their social group as young women. It's important to note that this aspect of implicit bias may only emerge in a particular context, such as discussion of sexual behavior. These findings regarding power and implicit bias show how broader social forces shape interpersonal communication in a dynamic process of privacy management. These results also demonstrate that disclosers and confidants cannot be assumed to hold the same power, and thus, autonomy and access to resources

in privacy management. In addition to this critical lens on privacy management, the results of this study emphasize the complexity of how patients view privacy management with their doctors.

Dialectical tensions. Participants' responses revealed dialectical tensions in their communication with physicians. Much of the previous research in this area focuses on the primary tension of autonomy and connectedness (Nodulman, 2011; Petronio et al., 2012; Plander, 2013). These results showed more complex aspects of different dialectical tensions in CPM, including openness/closedness, conventionality/uniqueness, and emotions/objectivity. For example, some of the results complicated dominant ways of discussing patient's communication as being truth or lies (Iezzoni et al., 2012; Tuckett, 2004), in contrast to open or closed privacy boundaries. Participants perspectives on private information about sexual behavior were echoed by one study that explored the distinction between deception and privacy management between sexual partners (Nichols, 2012). The findings of this prior study showed that participants held a privacy boundary around their information about sexual behavior, and didn't believe that they were engaging in deception if they believed that their romantic partner was not entitled to the private information (Nichols, 2012). The participants in the current study reiterated this perception of privacy management, and didn't characterize a close privacy boundary as "lies."

In the second theme of dialectical tensions, participants often explained that they simultaneously wanted to receive personalized, individualized treatment, and also that they wanted their doctor to be responsive to their unique life circumstances. Participants emphasized the fact that they didn't want the initiation of communication about sexual

behavior to be a response to some judgement about them as an individual; they wanted the topic to be broached as if the topic applied to everyone, and was "normal." Participants wanted to feel that they were compliant with the norms of the larger group, while also feeling that their individual needs and circumstances were important to the physician.

The tension between physician's emotions and objectivity have previously been raised in research about physician-patient communication (Petronio et al., 2012). In this dissertation study, the theme of the tension between emotions and objectivity shows that patients are concerned that their physician may have negative emotional reactions to their private disclosures about sexual behavior. Participant's fears about physician anger have been validated by research that shows that physicians do have reactions of anger as well as beliefs about the patient's culpability in cases of patients with cervical cancer (a cancer associated with sexual behavior), in comparison to patients with ovarian cancer (a cancer not associated with sexual behavior) (Liang, Wolsiefer, Zestcott, Chase, & Stone, 2019). These results add a category of dialectical tensions that can explain some of the antecedents and motivations for privacy management. In addition to theoretical advancements, this study holds practical implications as well.

Practical Implications

Patients want to open up to their doctors, and when a physician is aware that a patient is sexually active, this awareness provides the opportunity for sexual health counseling and treatment (Kelts et al., 2001). Physicians have the ability to not only provide patients with information about sexual health, but play a persuasive role in patient's decision-making and adherence to treatment (Harper et al., 2010; Huber &

Ersek, 2009). However, physicians' reluctance to talk about sexual has been attributed to a lack of training about how to discuss sexual behavior (Bull et al., 1999; Burd, Nevadunsky, & Bachmann, 2006; Hinchliff, Gott, & Galena, 2005). The results of this study provide rich data regarding some of the preferences female patients have when communicating with their physician about sexual behavior. Therefore, the results of this study have the potential to inform patient-centered training in the area of communication about sexual behavior, particularly with female patients.

Patient-centered care has been defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (Briere, 2001). It has been found that patient care outcomes are more strongly associated with patient's *perceptions* of communication, in contrast to evaluations from a third party (such as videotapes and analysis by researchers) (Bechtel & Ness, 2010). In the eyes of the participants in this study, certain factors were important in physician-patient communication about sexual behavior.

Participants in this study recognized several physician strategies to improve communication about sexual behavior. There was a general consensus that favored the use of transition statements. This finding corroborates previous research that shows that when physicians abruptly initiated communication about sexual behavior without providing context, they were less likely to successfully continue the communication about sexual behavior (Epstein et al., 1998), and were more successful when they provided context for the sexual health questions (e.g. "I ask all my patients about sexual behavior") (Epstein et al., 1998). However, participants in this dissertation study added that the introductory statements should naturally flow into conversation, not appear as if

reading from a checklist. Participants also echoed Epstein's et al. (1998) finding that at times, physicians prematurely changed the subject, directing the conversation away from sexual behavior. This change of subject was interpreted as a result of physician discomfort.

Finally, research shows that generally, patients are more willing to open up to physicians they believe to be competent communicators (Baker & Watson, 2015). This dissertation study shows that for female patients it is not just competence but also the meaning behind competence (e.g. nonverbal behaviors signaling a lack of negative judgment or bias) that shape patient's comfort. Participants in this study raised issues of physicians' implicit bias and judgment based on societal expectations and stereotypes. Because physician training is more prevalent and systematic than patient training, focus should be given to how to train physicians to recognize and attenuate the influence of implicit bias and societal expectations that prevent female patients from feeling they can open up to their physicians. One potential avenue to address the problems of implicit bias is by training physicians to reflect on the values that led them to become a physician (Hernandez et al., 2013), while also interrogating societal norms and taboos that seep into communication about sexual behavior. Training physicians to prioritize their goal of providing good patient care over their personal judgments regarding sexual behavior may help address this issue.

In light of this dissertation study, some existing protocols for training physicians about implicit bias could benefit from expanding to other social groups. Current research suggests that physicians should engage in self-reflections about their personal biases, and these activities may focus on social groups such as race (Hernandez et al., 2013). Future

activities may, in addition race, focus on encouraging learners to engage in self-reflection about their perceptions of patient's age, particularly young women, when communicating about sexual behavior.

The dialectical tensions extant in the results of this study provide several other potential applications to physician training. First, training exercises should address the false binary of truth and lies that dominates discussion of a patient's sexual history. One simple method of challenging this binary truth/lies frame is to invoke the boundary metaphor of Communication Privacy Management theory. These exercises can emphasize that as physicians, they are not entitled to patient's private information, and that a patient much choose to link them into a privacy boundary. These results also show that the physician statement "I ask all my patients this" can, when paired with individualized treatment, balance the tension between a patient's need for conventionality with their need to feel unique. Another dialectical tension extant in these data is the tension between a physician using objective reasoning, and harnessing emotions. Future training programs should focus on demonstrating how to balance the use of introductory statements and checklists while resisting assumptions about the individual, and reflecting on emotions and empathy. These exercises could involve practice using the checklists, while naturally maintaining eye contact, and gaining self-awareness about which emotions will serve their goals in communication with patients.

The findings of this study also illustrate how perceptions of physician's communication competence can encourage the opening of a privacy boundary. In addition to other aspects of communication competence, this study affirms previous research that suggests that nonverbal communication is key to favorable patient outcomes

such as patient satisfaction, adherence, and quality of life. (Beck, Daughtridge, & Sloane, 2002). Importantly, it is possible to train physicians to improve their verbal and nonverbal communication skills (Liu, Lim, McCabe, Taylor, & Calvo, 2016). Self-reflection and role-play activities can help physicians develop these skills, while also acknowledging the importance of the meaning behind verbal and nonverbal behavior.

Limitations and Future Directions

This study is limited by several factors. First, the results of this study only contain the perspectives of the patient and rely solely on their subjective perspectives of communication with their doctor. This subjective perspective can offer rich, in-depth information about patients' perspective on communication with their doctors, and particularly, patient-centered communication. However, use of interview methods are also vulnerable to the memory and recall ability of the participant. Further, their interpretation of the events is subject to influences in the time that has passed since the initial interaction and may be recalled through the lens of emergent factors other than their experience in the moment (e.g. learning about implicit bias in a college course). To begin triangulated research of this communication, continued research in this area can explore this privacy management through another methodological lens, such as through observations of communication between doctors and standardized patients (e.g. Bute & Brann, 2019).

A third limitation of the interview method is the fact that many of these participants based their privacy rule development on their interpretations of the physician's cognitions, emotions, and behaviors. While beliefs about a physician's implicit bias may be generally supported by research (Blair, Steiner, & Havranek, 2011;

Hernandez, 2018a; Liang et al., 2019), it is unlikely that they could extrapolate an individual physician's implicit biases.

The chosen sample of this study also creates a limitation; much of the participants in this group were in a transitory life stage, and their experiences with seeking healthcare about sexual behavior varied. Relatively inconsistent experiences with this communication is a product of this stage in the lifespan. Future studies can adopt a stronger focus on investigating the transitory aspects of this life stage, and how emerging adults make the transition to seeking out healthcare as they become independent from their parents.

Finally, many of the participant's perspectives on privacy management were not purely shaped by communication with their doctor, but developed out of a complex process of socialization through family, media, peers, and other sources. Future studies in this area can explore of privacy management with significant others such as family and peers shape perceptions of privacy management with physicians.

Conclusion

These results show that patients value the role of physicians, and want the opportunity to open up about sexual behavior, and make decisions with their doctors about their sexual health. The study also sheds light on the communicative factors that influence college student privacy management about sexual behavior, and shows how privacy management is born of dynamic interactions with the physician. This study also provides new findings in the area of implicit bias in doctor-patient communication. Further, results of this study introduced a new group of patients who perceive physician

biases because of their young age, and suggests a potential new consequence of perceived implicit bias- a closed privacy boundary.

Appendix A

Interview Protocol

You are here to participate in a research project studying college students' perceptions of how they talk about sexual behavior with their healthcare provider. You will *not* be asked to specifically talk about your sexual behaviors. There is no right or wrong answer to these questions; I want to learn more about what you think about communication about sexual behavior. The names of the people who participate, and organizational names and other identifying information will not appear in any transcriptions or reports resulting from this research. If I ask any question that makes you uncomfortable, you don't have to answer, and you may leave at any time. What questions do you have for me about the process? I'm going to be using fake names when I write up these data. I can make one up – or is there a name that especially suits you?

1) **How have your experiences been finding healthcare now that you are in college?**

2) **Tell me about who you talk to about sexual behavior… parents? Peers?**

3) **Tell me about the last time you went to see a healthcare professional related to sexual health?**
    (a) What topics do you consider to be information about sexual behavior?
        (i) to what extent would you consider consent to be a good topic?
    (b) When do you open up, and when do you shut down about sexual behavior?
    (c) Tell me about the place? Where did you talk about sexual behavior? Was this a clinic, or a family doctor, or hospital?

4) **Think about a recent or memorable conversation about sexual behavior with your healthcare provider.**
    i) What is it about the provider that makes it easy to open up, or shuts you down? What about
        (1) their communication styles?
        (2) their personality?
        (3) or other characteristics?

5) Tell me about how you decide what to tell your provider, and what to conceal?
    (1) Probing question about judgment:
        (a) How do you define judgment?

        (b) What about their communication style makes you perceive their level of judgment?

        (c) What other factors contribute to your perceptions of judgment?

(2) Probing question about bias?
   (a) are you concerned about physician bias?

   (b) what have you heard about physician bias?

   (c) how do you think you would respond?

   (d) do you think in the interaction you can prevent bias?

(3) Probing question about time:

   (a) What is it about your provider visit that makes you feel that there is limited time?

      (i) How is that communicated?

      (ii) How does that make you feel about sharing your private information?

      (iii) Have you ever felt a sense of urgency about when to open up about these issues?

(4) Probing question about humor
   (a) is it ever appropriate for a doctor to use humor? when and why? what is the boundary?

   (b) Would this make you open up more or less?

(5) Probing question about doctors sharing private information
   (a) has this ever happened to you?

   (b) how would you feel?

6) How do you decide what to share with a physician?
   (a) are there certain topics you would never broach?

   (b) are there topics you would assert yourself and made sure you brought up?

7) What haven't we talked about that would help me understand how you communicate about sexual behavior with your healthcare provider? Like, waiting for test results, your experiences in a waiting room, or the need to make a disclosure to your partner or family, or prioritizing talking to other people about sexual topics?

Demographic Questions

How do you identify regarding gender?

- Male
- Female
- Non-binary
- Prefer not to answer

What is your current age?

_____

How do you identify regarding race and ethnicity? (feel free to select more than one answer)

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- White
- Other _____

Please identify whether you are a:

- Senior

- Junior
- Sophomore
- Freshman

Are you currently:

- Single
- In a Relationship
- Married
- Divorced
- Other

Are you in a:

- Serious Relationship
- Casual Relationship
- No Relationship

Do you consider yourself to be:

- Heterosexual or straight
- Homosexual
- Bisexual
- Other
- Prefer not to answer

Do you identify as religious? If yes, what religion?

Where did you go when you wanted to talk about sexual behavior?

- Clinic
- Physician's private practice
- Hospital
- Not sure
- Other _____

Whom did you talk to about sexual health?

- Physician
- Nurse practitioner
- Clinic Nurse
- Other _____

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Weinstock, H., Berman, S., & Cates, W. (2004). Sexually transmitted diseases among American youth: Incidence and prevalence estimates, 2000. *Perspectives on Sexual and Reproductive Health*, *36*(1), 6–10.

Whaley, B. (2014). *Research Methods in Health Communication: Principles and Application*. New York, NY: Routledge.

Whitaker, D. J., & Miller, K. S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behavior. *Journal of Adolescent Research*, *15*(2), 251–273.

White, A. A., & Chanoff, D. (2011). *Seeing patients: Unconscious bias in health care*. Cambridge, MA: Harvard University Press.

Williams, S., Weinman, J., & Dale, J. (1998). Doctor–patient communication and patient satisfaction. *Family Practice*, *15*(5), 480–92.

Wimberly, Y. H., Hogben, M., Moore-Ruffin, J., Moore, S. E., & Fry-Johnson, Y. (2006). Sexual history-taking among primary care physicians. *Journal of the National Medical Association*, *98*(12), 1924.

Wittenberg, A., & Gerber, J. (2009). Recommendations for improving sexual health curricula in medical schools: Results from a two-arm study collecting data from patients and medical students. *The Journal of Sexual Medicine*, *6*(2), 362–368.

Wulfert, E., & Wan, C. K. (1993). Condom use: A self-efficacy model. *Health Psychology*, *12*(5), 346.

Yen, S., Parmar, D. D., Lin, E. L., & Ammerman, S. (2015). Emergency contraception pill awareness and knowledge in uninsured adolescents: High rates of misconceptions concerning indications for use, side effects, and access. *Journal of Pediatric and Adolescent Gynecology*, *28*(5), 337–342.

Young, J. W. (1979). Symptom disclosure to male and female physicians: Effects of sex, physical attractiveness, and symptom type. *Journal of Behavioral Medicine*, *2*(2), 159–169. https://doi.org/10.1007/BF00846664

Curriculum Vitae

Rachael Hernandez

Education

PhD	Health Communication Minor in Bioethics Indiana University-Purdue University Indianapolis Advisor: Sandra Petronio, PhD	2019
MA	Communication Texas A&M University	2010
BS	Communication The University of Texas at Austin	2008

Publications

Petronio, S. & **Hernandez, R.** (in press). "Communication Management Privacy Theory." In *Oxford Research Encyclopedia of Communication.* Oxford University Press.

Hernandez, R.A. (2018). Understanding sorority women's privacy management about condom use. *Qualitative Health Research, 28*(8), 1342-1353.

Hernandez, R.A. (2018). Medical students' implicit bias and the communication of norms in medical education. *Teaching and Learning in Medicine, 30*(1), 112-117.

Bute, J. J., Brann, M., & **Hernandez, R.A.** (2017). Exploring societal-level privacy rules for talking about miscarriage. *Journal of Social and Personal Relationships,* 1-21.

Ebersole, D. S., & **Hernandez, R. A.** (2016). "Taking good care of our health": Parent-adolescent perceptions of boundary management about health information. *Communication Quarterly, 64*(5), 573-595.

Smith, R. A., **Hernandez, R.A.,** & Catona, D. (2014). Investigating initial disclosures and reactions to unexpected, positive HPV diagnosis. *Western Journal of Communication, 78*(4), 426-440.

Hernandez, R. A., Haidet, P., Gill, A.C., & Teal, C.R. (2012). Fostering students' reflection about bias in healthcare: Cognitive dissonance and the role of personal and normative standards. *Medical Teacher, 35*(4), e1082-e1089.

Searle, N., Teal, C., Boyd, R., Friedland, J., Weigel, N., **Hernandez, R.A.,** Lomax, J., Coburn, M., Nelson, E. (2012). A standards-based, peer-reviewed teaching award to enhance a medical school's teaching environment and inform the promotions process. *Academic Medicine, 87*(7), 870-876.

Publications Under Review

Hoffmann-Longtin, K., **Hernandez, R.A.** An exploration of uncertainty management in medical education.

Teaching

Instructor	Indiana University Purdue University- Indianapolis	2019
	Interpersonal Communication (1 Section)	
Adjunct Professor	Marian University	2016-2017
	Public Speaking (3 Sections)	
Instructor	Pennsylvania State University	2011-2014
	Effective Speech (9 Sections)	
	Communication and Technology (7 Sections)	
	Group Communication (2 Sections)	

Instructor	Texas A&M University	2008-2010
	Public Speaking (9 Sections)	
Teaching Intern	Pennsylvania State University	2012
	Health Communication (1 Section)	

Research

Research Assistant, **Indiana University-Purdue University Indianapolis** 2015-present

Research Assistant, **Indiana School of Medicine** 2016

Researcher, **Pennsylvania State University** 2011-2014

Qualitative Analyst, **Baylor College of Medicine** 2012

Research Coordinator, **Baylor College of Medicine** 2010-2011

Research Coordinator, **Baylor College of Medicine** 2010

Graduate Intern, **New York City Department of Health and Mental Hygiene** 2009

Conference Presentations

Hernandez, R.A., (2018, November). A measure of college students' privacy management about sexual topics. *Paper presented at the National Communication Association Conference,* Salt Lake City, UT.

Petronio, S., **Hernandez, R.A.,** Vik, T., Thorson, A., Child, J. (2018, November). Lessons on teaching through crisis: The Penn State Sandusky Crisis. In "The play in teaching communication privacy management theory: The fun of observations and drama of regulating privacy." *Short course presented at the National Communication Association Conference,* Salt Lake City, UT.

Hoffmann-Longtin, K., **Hernandez, R.A.** (2018, November). Re-Conceptualizing uncertainty in the workplace: An exploration of uncertainty management in

medical education. *Paper presented at the National Communication Association Conference,* Salt Lake City, UT.

Petronio, S., **Hernandez, R.,** Vik, T., Thorson, A., Child, J. (2017, November). Lessons on teaching through crisis: The Penn State Sandusky Crisis. In "Legacy of teaching communication privacy management theory: Relevance to understanding privacy." *Short course presented at the National Communication Association Conference,* Dallas, TX.

Hernandez, R. A. (2017, November). A measure of college student's management of private information about condom use. *Poster presented at the Communication, Medicine, and Ethics Conference,* Indianapolis, IN.

Hernandez, R. A., Ebersole, D.S. (2017, June). A spectrum of explicitness: Parent-adolescent perceptions of family privacy management at the intersections of health, technology, and parental drug use. *Paper presented at the Communication, Medicine, and Ethics Conference,* Indianapolis, IN.

Bute, J.J., Brann, M., **Hernandez, R.A.** (2016, November). Societal-level privacy rules for talking about miscarriage. *Paper presented at the National Communication Association Conference,* Philadelphia, PA.

Hernandez, R. A. (2015, November). Medical students' implicit bias: An examination of the communication of norms in the hidden curriculum. *Paper presented at the National Communication Association Conference,* Las Vegas, NV.

Hernandez, R.A., Sharf, B. (November, 2013). Connecting with sisters: understanding sorority women's communication privacy management regarding condom use.

Paper presented at the National Communication Association Conference, Washington, D.C.

Ebersole, D., Nussbaum, J., Miller-Day, M., & **Hernandez, R.A.** (November, 2013). Parent-adolescent privacy management regarding personal and family health: A qualitative study about family privacy cultures and boundary management practices. *Paper presented at the National Communication Association Conference,* Washington, D.C.

Teal, C.R., Jarecke J., **Hernandez R.A.,** Haidet P. (2013, April). Pathways through the encounter: Comparing experienced clinicians' and students' interactions with patients. *Paper presented at the Regional Conference of the Southern Group on Educational Affairs of the of the Association of American Medical Colleges,* Savannah, GA.

Eberly, R.A., Gehrke, P.J., **Hernandez**, **R.A.,** Morris III, C. E., Rood, C., Saas. W. (2012, November) Reflections on communication privacy management, crisis, and classroom. *Presented in the panel"What Can Communication Scholars Learn from the Penn State Child Abuse Scandal?" at the National Communication Association Conference,* Orlando, FL.

Teal C.R, Jarecke J., **Hernandez R.A.,** Haidet P. (2012, June). Pathways through the encounter: How experienced clinicians recognize and follow patient clues. *American Association on Communication in Healthcare (AACH) Research & Teaching Forum,* Providence, RI.

Hernandez, R.A., Haidet, P., Gill, A., Teal, C. (2012, March). Fine tuning the inner voice: Use of personal standards to foster students' reflection about bias in

healthcare. *Paper presented at the Regional Conference of the Southern Group on Educational Affairs of the of the Association of American Medical Colleges,* Lexington, KY.

Hernandez, R.A. (2011, June). Reflection, relationships, and the hidden curriculum: Exploring relationship-centered care values among medical students and faculty. *Paper presented at the Regional Conference of the Southern Group on Educational Affairs of the of the Association of American Medical Colleges,* Houston, TX.

Hernandez, R.A. (2009, November) ¿Tiene hambre? An investigation of emerging trends in research on eating disorders in racial and ethnic minorities. *Paper presented at the National Communication Association Conference,* Chicago, IL.

Invited Presentations

Taking a sexual history. (2016, 2018) Foundations of Clinical Practice. Indianapolis, IN: *Indiana School of Medicine.*

Medical students' implicit bias: Norms in the hidden curriculum. (2015) Colloquium. Indianapolis, IN: *Indiana University - Purdue University Indianapolis*.

Medical students' implicit bias: A bioethical examination of norms in the hidden curriculum. (2014) Bioethics Colloquium. State College, PA: *Pennsylvania State University.*

Connecting with sisters: Understanding sorority women's communication privacy management regarding condom use. (2013) Communication Arts and Science Colloquium. State College, PA: *Pennsylvania State University.*

Gender, sexuality, and dating. (2010) Radio broadcast. College Station, TX: *Our Voices, Ourselves*.

Beyond the birds and the bees: How to communicate with your child about sex. (2009) Radio broadcast. College Station, TX: *Fair and Feminist Radio.*

Beyond the megaphone: Communication and outreach between NYC communities and the NYC Department of Health and Mental Hygiene. (2009) Research presentation. New York, NY: *Health Research Training Program.*

Service

Reviewer

Health Communication	2018
Journal of General Internal Medicine	2018-present
NCA Conference, Health Communication Division	2018
Teaching and Learning in Medicine: An International Journal	2017-present

Committee Member

Educational Policy Subcommittee, Indiana University School of Medicine	2016-2017
Hiring Committee, Pennsylvania State University	2013-2014
Technology Committee, Pennsylvania State University	2012-2013

Leadership

Community Chair, Graduate Student Forum, Pennsylvania State University	2013-2014
Mentor, Instructors Mentorship Program, Pennsylvania State University	2012-2013
President, Graduate Student Forum, Pennsylvania State University	2012-2013
Chair, Communication Graduate Student Council, Texas A&M University	2009-2010

Volunteer

Communication, Medicine, and Ethics Conference	2017
National Communication Association Graduate Fair	2015, 2013, 2012
Amanda Kundrat Memorial Blood Drive, Pennsylvania State University	2012-2014
Women and Minority Health Resources Group, New York City	2009

Awards

IUPUI Communication Travel Award	2018
Petronio-Bantz Travel Award, IUPUI	2018
National Communication Association Caucus Student Travel Grant	2018
IUPUI Communication Travel Award	2017
IUPUI Communication Travel Award	2016
Nomination for Outstanding Graduate Student Paper, IUPUI	2015
National Communication Association Caucus Student Travel Grant	2015
Petronio-Bantz Travel Award, IUPUI	2015
IUPUI Communication Travel Award	2015
Teaching with Technology Certificate	2014
Bunton-Waller Graduate Scholarship, PSU	2011-2014
National Communication Association Conference Travel Award, PSU	2014
National Communication Association Conference Travel Award, PSU	2013
National Communication Association Conference Travel Award, PSU	2012
National Communication Association Conference Travel Award, PSU	2011
National Communication Association Conference Travel Award, TAMU	2009
Top Ten Percent Combined Teaching Rigor and Evaluations, TAMU	2009