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"I Wouldn't Be this Firm if I Didn't Care": Preventive Clinical Counseling for Reproductive Health

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Abstract

Objective—This qualitative study of the health care clinicians serving women at heightened risk of sexually transmitted infections and unintended pregnancy was undertaken to explore concepts underlying reproductive health counseling messages in clinical encounters.

Methods—In-depth interviews were conducted with 31 clinicians, including physicians and advanced practice clinicians serving primarily low-income patients in high-risk communities throughout the U.S.

Results—Most of the clinicians describe their influence on patients and protective behaviors as derived from medical authority and the presentation of information. The use of a parental style of authority, particularly for young or vulnerable patients, and emotional appeals to evoke negative emotions, such as fear, were also used to motivate protective behaviors. Many clinicians highlighted the importance of empathy, and understanding the cultural and social context of health behaviors. A few clinicians described innovative efforts to empower women to protect themselves and exert more control in relationships.

Conclusion—Some of the reproductive health counseling approaches described by clinicians are not consistent with leading health behavior change theories or patient-centered counseling. To improve counseling, these messages and concepts need to be evaluated for effectiveness, and possibly used to inform the development of novel theories for use in reproductive health counseling.

Keywords

reproductive health; clinical counseling; behavior change theory; patient-centered care; contraceptive counseling; sexual health

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1. Introduction

Despite high rates of unintended pregnancy and sexually transmitted infection (STI) in the United States, and public health goals to reduce prevalence [1], surprisingly little research has identified effective counseling approaches for use in clinical settings to influence sexual risk behavior [2,3]. A number of theory-driven interventions to reduce HIV/AIDS acquisition and transmission have been successful in community and clinic settings, but generally are implemented with specially trained study staff [4,5]. Recent reviews of the literature on contraceptive and STI prevention counseling call for development and testing of interventions that can be applied in health care settings [2,6–8].

Women's interactions with health care providers present important opportunities to educate, offer resources, and counsel patients to change risk behaviors [9]. Yet, we lack theory-driven research to inform patient counseling on unintended pregnancy, and consensus on the most effective messages for contraceptive counseling in clinical settings [3,10]. Two fields of research provide context for our study of clinicians' reproductive health counseling: 1) clinical interaction studies and the concept of patient-centered care, and 2) health behavior change theory.

Observational studies of the clinical interaction from the patient and clinician perspective offer insight into the importance of interpersonal dynamics in quality of care. Clinical interaction research focuses on qualities of communication, such as empathy [11,12], qualities of the relationship such as trust and respect [13], or personal characteristics, such as gender and race, that influence interactions [14]. The degree of patient-centered care, or shared decision-making, is a concept that has become increasingly important for evaluating clinical interactions. According to patient-centered models, psychosocial circumstances of individuals are relevant, in addition to biological processes and medical needs. Patient-centered communication is intended to increase patient disclosure and facilitate patient involvement in decision-making [15]. The approach has been used to improve care for a range of health conditions [16,17], but few studies have examined the effectiveness of patient-centered care in reproductive health counseling [18].

Clinical interaction literature is not easily integrated with research on health behavior change. Clinical interaction studies have identified communication styles consistent with patient-centered care, but not mechanisms for eliciting health behavior change. An extensive literature has developed and tested theories of behavior change for diverse populations, settings, and health conditions. In a recent Cochrane Review of theory-based interventions for contraceptive counseling [10], social cognitive theory was widely used, with constructs focused on skills, cultural norms, self-efficacy, goals, and social support for protective health behaviors [19]. Yet, few interventions to increase effective contraceptive use were beneficial, and interventions using clinician counseling at health visits were uncommon.

There is not a well-tested and consistently applied theoretical model for counseling in preventative reproductive health care, leaving clinicians with little guidance on counseling that is most likely to be effective. Counseling approaches used by clinicians most likely are derived from a number of sources—professional education, clinical training, knowledge of behavior change theory, personal beliefs, and life experience [20]. Clinicians' descriptions of efforts to bring about behavior change in their patients, and their views concerning what is effective, are considered in this study. We further analyze whether concepts that emerged from clinician interviews are consistent with leading behavior change theories or tenets of patient-centered care. The findings may inform the development of conceptual models for reproductive health counseling.

2. Methods

2.1. Setting and Data Collection

We conducted in-depth interviews with clinicians serving low-income women. The recruitment strategy was designed to obtain a diverse selection of approximately 30 clinicians serving women at heightened risk of unintended pregnancy and STI/HIV. Obstetrician-gynecologists, family medicine physicians, certified nurse-midwives, and nurse practitioners were included. Data from the Centers for Disease Control on HIV prevalence [21] and information from local health departments were used to identify communities reporting high rates of HIV among women. Recruitment areas were purposively selected, using census data, to optimize diversity by region, population density, and race/ethnicity. The recruitment areas were: Essex County, New Jersey; Washington, D.C.; Bamberg and Sumter Counties, South Carolina; Edgecombe, Lenoir, Martin, and Durham Counties, North Carolina; St. Lucie and Miami-Dade Counties, Florida; and City of Oakland and San Diego County, California. These areas have high rates of STIs among women of reproductive age, particularly young, low-income and minority women [22].

Potential participants were identified using clinician listings and directories, and telephone consultation with professional contacts, community clinics, advocacy organizations, and public health departments. Clinicians were contacted by mail and telephone, and if eligible (i.e., active patient care for family planning and STIs), invited to participate. Of 39 screened clinicians (37 eligible), 31 participated: 10 physicians and 21 advanced practice nurses (14 nurse practitioners, 7 certified nurse-midwives). We obtained informed-consent and authorization to audiotape before the interviews, and provided $100 as remuneration. From June–November 2005, one of two trained female interviewers interviewed the clinicians, usually at their practice, using a semi-structured topic guide (mean interview length = 72 minutes, range 31–110).

The topic guide was reviewed by clinician advisors and piloted by five physicians and nurses (nurse practitioners/midwives). We sought clinicians' views on a range of topics on contraceptive and STI/HIV prevention counseling, and presented a series of patient scenarios [23] (Table 1). The study was approved by the University of California, San Francisco Committee on Human Research.

2.2. Analysis

Interviews were coded using Atlas.ti 5.0 [24] to apply question-specific, content and *a priori* themes based on past research (deductive codes), and those emerging from the data (inductive codes). The inductive codes were developed using a grounded theory approach [25,26]. Two independent analysts coded the data, and the research team met several times to review and discuss results. Decisions about theme names and grouping of quotes were made by the study group using an iterative process of transcript reading, coding, and analysis. Additional inductive thematic codes were used to organize concepts that emerged after re-reading the transcripts and initial codes. The analysis identifies commonly expressed views, but also unique and alternatives views. Quotes were selected to highlight commonalities and diversity in clinician approaches. In the final analysis stage, we examined the compatibility of the counseling approaches with health behavior change models used in reproductive health research.

3. Results

Study participants were primarily women, reflecting a high concentration of women in nursing and reproductive health professions, and they were from varied racial/ethnic backgrounds (Table 2). The clinicians described their patient populations as racially and

ethnically diverse, including immigrant and foreign-born patients. All accepted Medicaid, describing the most patients as low-income. All cared primarily for women of reproductive age. Clinicians described a variety of strategies and messages aimed at influencing or changing patient behavior, and many referred to the importance of ascertaining patient characteristics, risk behaviors, and history along with broader inquiry into psychosocial and cultural circumstances. In the next sections, we discuss five dominant themes from the interviews.

3.1. Information as influence

Most clinicians believed they could exert influence on their patients' contraceptive choices, primarily through the way they presented information. Clinicians described emphasizing different benefits and side-effects of methods to influence patient choice.

> *I would like to think that I'm totally open to whatever you would like but I think I kind of steer—you know, I've been doing this for so long that I kind of steer people to something I think they're going to be able to use correctly and completely.* (Certified Nurse-midwife)

> *I think [I have] a lot [of influence] because it all depends on how you present it to the patients, and how proactive you are in encouraging them to try it.* (Obstetrician-gynecologist)

> *I think it's a lot and I think it's all in how you spin it [contraception] …It's all how you present your information, and I usually try to present it in a fair way based on their history.* (Nurse Practitioner)

Clinicians said they used their clinical judgment to assess what method would be most effective for a patient. Many recognized the importance of eliciting the patient's perspective to facilitate choice based on her own interests, qualifying their descriptions of influence with statements of patient choice and joint decision-making.

> *I think we have quite a bit of influence … if you highly recommend one method over another, they're going to take that to heart because they're going to think that you know better than them, which in a lot of cases we do but— I think people also can put their bias into it… And so I think we do have a lot of influence on what they choose, especially if you educate them and tell them this is your reasoning why you think this would be better than this, then you can definitely influence them.* (Certified Nurse-midwife)

Clinicians suggested that sharing health information and dispelling myths about contraception and STIs were important parts of the clinical interaction. Many cited patients' low levels of basic reproductive knowledge and misconceptions, and described their influence on patients as deriving from the information they communicate. They were aware that by selectively presenting information, they exercised power. A few clinicians expressed ambivalence about their influence on contraceptive choice; others seemed to view it their role to simplify the amount of information offered in order to help patients.

3.2. Authority to influence

Clinicians described how they drew on authority to influence and guide patients. Their sense of authority derived from professional expertise, or from a parental orientation toward patients, based in age differences and protectiveness. A directive "tough-love" approach was often mentioned, especially with younger patients.

> *Sometimes when I'm really, really firm with them, I can see they're getting upset, and I'm always like, 'I wouldn't be this firm if I didn't care.' You know? And it brings 'em back. And I think they listen…* (Obstetrician-gynecologist)

One clinician said a firm demeanor was particularly important with patients who might be pressured into having sex.

> *I feel like they need someone to be very strong and firm with their life, kind of like children like discipline, I think this patient population needs a strong person, so I'm always like, "What are you going to use?" Not like, "What do you want?" "What are you going to use?" More of that kind of thing, and I'll bring them back more often.* (Obstetrician-gynecologist)

Similarly, a certified nurse-midwife believed her medical authority was important, especially for teen patients.

> They'll still listen and take that information a little more to heart than maybe their mother's information even though it's the same information just because I've got that medical person authority.

An Obstetrician-gynecologist described her advice to a patient – "If he won't put the condom on, throw him out" – as "maternal". Others mentioned being careful not to take on a maternal tone with teenagers, because they thought it would lead them to discount their advice.

3.3. Scare tactics

Most clinicians believed patients are not aware of their risks for pregnancy and STIs, and talked about efforts to make an emotional impression that might motivate behavior change. Messages intended to elicit fear and even disgust were described.

> *I always throw in a couple of scare tactics in there and a couple of stories about other people, what happened when other people – you know, oh, I had a patient once that did this, that and the other thing. This is what happened to her.* (Nurse practitioner)

> *It's almost like a scare tactic, because I've just, again that invincible thing, I just, I want to break that so I'm just kind of like… "It could prevent you from becoming pregnant, never have a child", and then just run it home, and, like HIV … "do you want to die?"* (Obstetrician-gynecologist)

Another clinician described efforts to attach feelings of disgust to the act of unprotected intercourse.

> *I'll use the analogy about if you go to a restaurant and you're given a plate that's dirty, would you eat off of it? And they usually react Ew, that's gross. And then I'll say well then why would you allow somebody to put his penis inside of your vagina when you don't know where that penis has been previously.* (Certified Nurse-midwife)

Clinicians expressed concern about low perceived risk and attitudes of invincibility in their patient populations, and a few used pictures of STIs and cautionary tales based on negative experiences of other patients. One clinician, however, said it was important to avoid overwhelming patients.

3.4. Connection and empathy

Many clinicians discussed their cultural distance from patients or affinity with them; some referring to their personal characteristics as important for effective counseling. One Latina clinician notes:

> *I have colleagues here that – in the same role, we think alike and we're out to protect them. And I think it helps that we're young and the way we talk to our patients. I make it very approachable.* (Family Medicine Physician)

Others described their awareness of socio-cultural distance.

> *I mean, I'm a Caucasian lady, I'm older than everybody and, … 'I know you don't want to hear this from me, but you have to listen, you know'. As I said, I don't know how much goes in or how much they really believe they're at risk.* (Certified Nurse-midwife)

Efforts to put patients at ease by acknowledging the complexity of sexual feelings and behavior were described by a few clinicians, in this case to improve disclosure during history-taking for topics that patients might find embarrassing or shameful.

> *I ask people to think about the forgettable man. Don't tell me about your relationships. There might be people you had sex where you say, "Oh, my God, what was I thinking? [laughs] 'Cause people have those moments too, and I'm giving them the opportunity to understand a doctor understands that that is normal behavior too. So a lot of this stuff about getting the history has to do with how you ask the question.* (Obstetrician-gynecologist)

Understanding and relating to the larger context of patient reproductive health behaviors contributed to empathy, but was at times also accompanied by frustration with the inability to protect patients.

3.5. Empowerment

Clinicians rarely referred to counseling messages on women's sexual pleasure, but some tried to empower women to care for themselves and take ownership of their sexual experiences.

> *Obviously we tell them that this is your body. It's what you want. And your partner … does not need to know because you are going to be carrying the pregnancy yourself… We tell them it's just like you put on your make-up, you brush your teeth every day. You do this for a reason – because you want to feel good about yourself… So the same thing with using condoms or using anything that keeps us healthy.* (Nurse Practitioner)

> *I talk about their body as a temple, looking at their body as a temple and that it's sacred territory, and that there are decisions that they can make in terms of partners that they choose, and that condom use should be like brushing their teeth, that it's no longer an option.* (Certified Nurse-midwife)

An Obstetrician-Gynecologist described instructing women to take control of condom use, for their protection: "Don't make him put his own condom on, put it on yourself, learn how to do it… it's a woman's job to get it on there."

Building the confidence of women, both personally and in their relationships, seemed to be the aim of some counseling approaches. As a Nurse Practitioner said in response to the patient scenario involving the 24-year-old: "You're a smart young lady. It is so important to get a good guy and be faithful,…try and make sure he's faithful and stick with one guy."

Many clinicians acknowledged the challenge of counseling women in the face of gender and power dynamics and male behaviors beyond their control.

4. Discussion & Conclusions

4.1. Discussion

In the absence of widely used, evidence-based approaches to preventive reproductive health counseling, clinicians describe a range of practices. Some approaches include components of behavior change theory, but many are not represented in current conceptual models, indicating a need for development of testable theories for use in clinical counseling for prevention of unintended pregnancy and STIs.

Most clinicians believed they influenced patient contraceptive choice, particularly with presentation of information and education. The clinicians we interviewed were aware that clinical judgment about what information patients need can translate to influence over method choice. Such recognition highlights a tension between the ideal of fully informing patients of options and allowing them to make independent choices, and the reality of clinical care. The clinicians we interviewed draw on extensive clinical experience, and undoubtedly know which methods their patients tend to have the greatest success using. Further research is needed to understand the costs, benefits, and outcomes from prioritized and selective presentation of information.

Clinicians referred to low risk-awareness, particularly among younger patients, and consequently described approaches aimed at increasing risk perceptions to bring about behavior change – including “scare tactics”. The use of fear appeals in an effort to bring about behavior change has been theorized and tested in the psychological literature in the context of public health campaigns [27,28]. Current understandings suggest that eliciting a strong fear response can undermine behavior change, particularly in the absence of adequate resources and self-efficacy for protective behaviors.

Drawing on negative emotions to bring about behavior change is not a component of patient-centered models or health behavior change theories; better understanding of the prevalence and outcomes of such counseling is needed. While the health belief model [29] and others discussed below recognize that risk-perception is an important component of behavior change, research should investigate whether using fear, disgust or shame to increase perceived risk contributes to behavior change, as some clinicians may assume, or if these approaches are counterproductive in clinical settings and undermine disclosure or communication. The prevalence of this kind of counseling and its consequences for aspects of the patient-physician relationship, such as trust and rapport, also warrant investigation.

Other commonly applied theories for contraception and STI prevention interventions – social cognitive theory [19] and the information-motivation-behavioral skills model [30,31] – focus on accurate risk-perceptions and understanding of personal and contextual factors that might contribute to health behaviors. Social cognitive theory also focuses on self-efficacy and modeling protective behavior [19]. Notably, the clinicians interviewed did not refer to counseling that describes how other young women successfully avoid unintended pregnancy and STIs; instead they were concerned with impressing upon patients their degree of vulnerability. Counseling highlighting positive rather than negative peer experiences would be consistent with the theory of reasoned action, as it recognizes the influence of social pressure and norms on health behaviors [32,33].

Some clinicians made efforts to empower women, recognizing that gender inequalities influence sexual decisions and health outcomes [34,35]. Despite an absence of evidence-

based guidance on ways to address gender and power in clinical counseling, clinicians described innovative approaches; for example, encouraging thoughtful partner selection, discussing life goals, and framing protective behaviors as personal hygiene. Some clinicians acknowledged constraints of relationships on women's ability to protect themselves, and articulated a need for empathy and encouragement for small steps toward protective behaviors.

Clinicians noted the importance of relating to patients—some expressing difficulty and others confidence. A recent study of Title X clinic patients identified empathy and non-judgment as features of care most highly valued by patients from diverse cultural backgrounds [36]. The importance of cultural understanding and empathy from clinicians is also evident in healthcare research on African-American and Latina patients [37,38]. In our research, clinicians noted that being able to identify with patients affected the ability to develop rapport. Training in reproductive health counseling that incorporates cultural competency and empathic communication skills could benefit both clinicians and patients by improving the interpersonal quality of interactions [39,40].

Many clinicians described the use of authority to guide and influence patients, particularly young or vulnerable patients. The invocation of authority in clinical communication has not been advocated or studied in recent years, but needs to be investigated. A study of teenage contraceptive clients conducted over 20 years ago identified a strong positive effect of authoritative counseling on contraceptive compliance [41]. The study examined three dimensions of the counseling interaction: scope of counseling, trust in the clinician, and use of influence (persuasion and authority). Each contributed to contraceptive use, but authority was most influential. Whether the use of authority would have a similar effect today is not known, but some clinicians in our study using these approaches described them in positive and caring terms (i.e., "tough-love").

In keeping with recent formulations of patient-centered care, it is possible that some patients would prefer and benefit from directive counseling [16]. However, there is variation among clinicians and their relationships with patients, as some mentioned concern about being perceived as an authority figure by patients, and thereby less able to connect. Furthermore, young women seeking reproductive health care, in a recent study, expressly wished to be treated with greater autonomy and respect by clinicians [36]. The transition between childhood and adulthood may be particularly complex with regard to authority, because full decision-making autonomy will not always be recognized by the clinician or felt by the patient. Indeed, many clinicians described a tendency to relate in a parent-child or adult-child dynamic. Further research about the possible benefits of authoritative and directive counseling for reproductive health is needed, but must take into account the potential for authority to be misused, coercive or counterproductive.

Motivational Interviewing (MI) is a counseling technique that combines elements of patient-centered care with directive guidance. Developed by psychologists treating addiction, potential benefits of MI for other health conditions have been suggested [42–44]. Randomized trials of reproductive health interventions including HIV risk reduction, alcohol prevention during pregnancy, and repeat births to adolescents have been variable in their findings, with some showing benefits [5,45–48]. Efforts made by clinicians in our study to empower and empathize with patients are consistent with MI, as are some directive approaches. MI encourages clinicians to trust the autonomy and capacity for growth in patients, and to actively guide patients toward their own motivation for change.

Our study has limitations. It is based on clinicians' descriptions of their clinical approaches; how closely the interviews reflect what actually occurs in clinical encounters is unknown.

Social-desirability bias would increase reports of ideally provided care in concordance with professional norms and expectations. The diversity of responses and variation in practice suggest that this bias did not dominate our findings. The clinicians we interviewed may have different approaches to counseling and a greater focus on risk compared to clinicians serving lower-risk populations. We did not directly ask clinicians why they rely on particular counseling approaches, although they reported using approaches they thought would be most effective. Finally, we are unable to draw conclusions about clinician differences in age, gender, or training due to the qualitative study methodology.

Despite these limitations, our investigation illustrates how clinicians endeavor to counsel and protect their patients, offering insight into concepts and implicit mechanisms underlying counseling messages. Unlike quantitative surveys, this inquiry allows us to better understand the approaches and intentions of clinicians, and attends to the complexity and challenge of reproductive health preventive counseling from the clinician perspective.

4.2. Conclusions

Considerable research evidence has accrued for clinical preventive care for health behaviors, such as smoking, addiction, and management of chronic diseases, but features of reproductive health counseling may make translation of effective practices in those areas less applicable. In reproductive health counseling, gender inequality, relationship dynamics, and a diverse range of normative beliefs about sexual behavior heighten the complexity of patient-centered care. As demonstrated by these interviews, clinicians recognize this complexity and endeavor to protect high-risk patients, despite a lack of evidence-based research on effective counseling practices. Efforts to empower women, encourage self-care, and connect with patients through empathy were described, as were approaches using authority and evoking negative emotions. Further research should assess how and why clinicians develop different counseling approaches and which are associated with positive patient outcomes. Finally, a conceptual model encompassing the patient, the clinician, and their interaction is needed to design and test interventions for reproductive health counseling in clinical settings.

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Table 1

Sample items from the interview topic guide

Description of practice and patients	Are patients routinely counseled for family planning or STI prevention, or just in certain circumstances? Can you describe how you assess your patients' risk for unintended pregnancy? How would you describe your patient populations? *Do you serve any immigrant populations? Do you serve Medicaid patients?*
Counseling perspectives	As a health care provider, how much influence do you feel you have over your patients' method preferences? For your patients who aren't pregnant, what do you do to help them prevent pregnancy? *What do you usually talk about?* What do you do to help your patients prevent HIV and STIs (such as Chlamydia or Herpes)? What about women who might be pressured into have sex by their partner? *How do you help them avoid unintended pregnancy?*
Patient scenarios	The first patient scenario is a 24 year-old woman who has a university education. She is not married, has had several sexual partners over the past year and frequently uses condoms. Her reason for the clinical visit is that she's worried that she might have an STI and is concerned about preventing pregnancy. *What would your approach to this patient be? What would you discuss with her?* The second patient is a 16 year-old student. She is not married, she has never been pregnant. Her partner is 24 years old, and they sometimes use condoms. Her reason for the visit is she's worried that she might have an STI. *What would your approach to this patient be? What would you discuss with her?* The last patient is a 36 year-old married woman, with a grade-school education. She has 6 children, does not want more, but has never used contraception. Her husband refuses to use condoms. Her reason for the visit is contraception. *What would your approach to this patient be? What would you discuss with her? What if at the visit you discovered that she has STI symptoms? How would this change the discussion you have with her?*

Table 2

Characteristics of Clinicians and Practice Settings, n = 31

	Number of participants
Professional Title	
Physicians (n=10)	
Obstetrician-gynecologist	7
Family medicine	3
Advance Practice Clinicians (n=21)	
Nurse practitioner[1]	14
Certified nurse-midwife	7
Practice type[2]	
Non-profit/public (n = 24)	
Community health clinics	12
Family planning clinics[3]	12
University	5
Private	2
Geographic area	
Rural	8
Suburban/Urban	23
Median Age [Range 32–62]	48
Gender	
Female	28
Male	3
Race/ethnic identity	
White	16
African-American	8
Latino	4
Asian	2
Multi/other	1

[1] One nurse practitioner (classified as such in this table) was also a certified nurse-midwife.

[2] 13 of the 31 practices received Title X Funding

[3] 8 of these are Planned Parenthood clinics