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# Women's preferences for contraceptive counseling and decision making

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## Abstract

**Background—**Little is known about what women value in their interactions with family planning providers and in decision making about contraception.

**Study Design—**We conducted semistructured interviews with 42 black, white and Latina patients. Transcripts were coded using modified grounded theory.

**Results—**While women wanted control over the ultimate selection of a method, most also wanted their provider to participate in the decision-making process in a way that emphasized the women's values and preferences. Women desired an intimate, friend-like relationship with their providers and also wanted to receive comprehensive information about options, particularly about side effects. More black and Spanish-speaking Latinas, as compared to whites and English-speaking Latinas, felt that providers should only share their opinion if it is elicited by a patient or if they make their rationale clear to the patient.

**Conclusion—**While, in the absence of medical contraindications, decision making about contraception has often been conceptualized as a woman's autonomous decision, our data indicate that providers of contraceptive counseling can participate in the decision-making process within limits. Differences in preferences seen by race/ethnicity illustrate one example of the importance of individualizing counseling to match women's preferences.

### Keywords

Counseling; Shared decision making; Contraception; Race/ethnicity; Patient preferences



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## 1. Introduction

Underuse of effective contraception is one factor which contributes to high rates of unintended pregnancy in the United States [1,2]. While contraceptive use is affected by a complex network of factors including access to medical care, lack of insurance coverage and patient knowledge, patient–provider communication is another important factor to consider. Health communication is regarded as an important marker of quality of care by the Institute of Medicine [3] and is associated with patient outcomes [4,5].

Observational studies support the importance of the provider–patient relationship in family planning care, with associations between satisfaction with interpersonal aspects of care and contraceptive use and continuation [6–8]. Despite the importance of the provider–patient relationship, attempts to improve contraceptive use through counseling interventions have had limited success [9]. One possible reason is a lack of research regarding what women value in their interactions with family planning providers.

One area of communication with relevance to family planning is control over the decision making process. In the health communication literature, studies have found that many patients prefer shared decision making, in which both the provider and the patient contribute to the choice of medical treatments [10]. There are variations in preferences, however, with some patients preferring to make decisions autonomously and others to have the health care provider make decisions for them [10,11]. Furthermore, there appears to be intraindividual variation in decision-making preferences depending on the specific health care decision [12]. Regardless of the specific preference, studies have suggested that providers who facilitate the patient's preferred model of decision making may improve patient outcomes [13].

In the field of family planning, there has been an emphasis on the autonomous, or "informed choice," model of decision making [14–16], in which the provider's role is to provide objective information to the patient in order to facilitate her choice of a contraceptive method after assessing for medical contraindications to specific methods. While the provider may personalize the information in order to be most relevant to the needs of the patient, he or she does not participate in the process of selecting the method, which is seen as solely the responsibility of the patient. It is unknown whether this autonomous model of decision making meets women's needs in choosing a contraceptive method. Previous qualitative studies have indicated that women value autonomy in contraceptive decision making, but have not investigated the details of the decision making process and the appropriate level of provider involvement [17,18]. A recent study about decision making around contraception in the United States found that women were significantly more likely to prefer autonomous decision making about birth control than other medical issues [19]. However, there was substantial variation in preferences, with 50% of women desiring some input from their provider.

This study aims to assess patients' preferences about birth control counseling, with a focus on the decision-making process, with the goal of informing future efforts to devise counseling interventions aimed at improving contraceptive use.

### 1.1. Racial/ethnic differences in contraceptive counseling preferences

In considering provider–patient communication about contraception, an additional factor to take into account is the race and ethnicity of the patient. African–Americans and Latinas may be more distrustful than whites of the health care system [20], and given the historical connection of some coercive family planning programs with racist beliefs [21], these concerns could be amplified in the context of contraception. Given the significant racial and ethnic disparities in unintended pregnancy in the United States [22], any differences in how minority patients experience contraceptive counseling and contraceptive decision making are of particular interest in studies of provider–patient communication.

## 2. Methods

We conducted semistructured, in-depth interviews with adult women between January and May 2009. Women were recruited at five clinics in the San Francisco Bay Area after receiving contraceptive counseling. Four of these clinics provide primary care services, while the remaining clinic is a general obstetrics and gynecology clinic. Participation rates were not formally tracked. Selection criteria for patients were that they were black, white or Latina; over the age of 18 years; and English or Spanish speaking. Interviews were carried out in either English or Spanish based on the woman's preference. The interview guide began with basic demographic questions and then explored women's experiences and preferences around contraceptive counseling, focusing on the decision-making process.

Patient recruitment was stopped when saturation was reached for the identified themes. Consensus codes were reached by three researchers through an iterative process using modified grounded theory, incorporating a previously determined coding structure as well as allowing new themes to arise inductively from the data.

The study protocol was approved by the University of California, San Francisco, Committee on Human Research.

## 3. Results

### 3.1. Population

Table 1 presents the characteristics of the 42 participants. White and English-speaking Latina participants were older and reported higher levels of education than blacks and Spanish-speaking Latinas; they also had the fewest number of children.

### 3.2. Control over contraceptive decision making

The vast majority of patients felt it was appropriate that they make the final decision about which birth control method they would use. However, most women did want providers to actively assist them in deliberating about their options and determining the best method for them. Provider involvement in the deliberation process was most often seen as positive if it reflected patient concerns and preferences. For example, one woman stated:

> "I guess the best way is to tell them all the choices they have and to try to find out what is better for each person because everyone is different. So some things work

> for some people, some things don't work. So if they give them all the choices and they try to find out what is better for them or what kind of person they are, that will help them take the best decision."

In addition to providing support with deliberation, approximately half of the respondents reported that, in their most recent counseling session, their provider in fact had expressed a specific preference or suggestion which influenced their method choice. Patient responses about this type of input were predominantly positive or neutral; only a few had negative responses. A few women specifically indicated that the provider's opinion was welcome if it was elicited or was accompanied by an explanation of the underlying reason, such as safety concerns. In general, if stated in an appropriate manner, provider opinion was seen as helpful to women in making decisions.

> "Yeah. I mean, you know, if I feel comfortable that a doctor has a preference because it's safer or it's been researched more or there's not as many health concerns.… So if someone did have a preference I would want to feel that the reason that they had a preference was because of safety and I would want, you know, I would be able to tell why … they were having that preference."

Several women indicated that provider opinions were welcome in very limited circumstances, for example, when the women had specifically invited it. One participant spoke about the need for caution when making a suggestion in order to prevent any appearance of pressure.

> "The client should hear the provider's opinion. And then like if the client likes it, you know, then they can talk more about it, you know? But if not, if the client doesn't like it, then the provider should just get off talking about it and try to like — compromise."

Few women expressed negative attitudes about provider opinions, but of those who did, some specified that they wanted facts and not their provider's opinion or anecdotal experience about what was good or bad. Negative attitudes arose when women felt forced to use a specific birth control method. One woman described a negative experience with counseling about intrauterine contraception:

> "Well, I had previously, I'd been on Yasmin.… And when I talked to the doctor about being on Yasmin and needing, you know, a refill quite soon, he was kind of like, 'No, I think you should get an IUD instead.' And like it was, I really did have like a pretty negative experience with them.… Like I felt almost bullied into getting it.… And like, I mean it's fine. You know, it's a great method. But I liked the Yasmin that I was on."

### 3.3. Interpersonal relationship with provider

In the context of discussing contraceptive decision-making, some women expressed a preference for a provider–patient relationship that felt familial or friend-like. As visits for birth control counseling can bring up uncomfortable topics including sexual activity and risk of pregnancy, having a provider who was less formal and more caring was associated with an increased comfort level. One patient described her preference in this way:

> "I guess I feel like the best experiences I have are when the person, the provider, almost has like a maternal instinct to me, I mean you do have to have a certain amount of nurturing when you're talking about that because if you're too clinical, it's just, it's people's, it's their sex life; it's not just black and white."

Many patients mentioned that having a long-standing relationship with a provider influenced their comfort level. A few women had seen the same provider for years. They appreciated that the provider knew their history, and over time, they felt less awkward discussing sensitive issues.

> "I just think over time you get comfortable. It's like knowing someone. He doesn't just make me feel like I'm a patient. He makes me feel like he's really concerned and like I'm a family member."

### 3.4. Preferences for information

One of the most common priorities for women in contraceptive counseling sessions was the comprehensiveness of information provided. Patients often appreciated learning about alternative methods, even if they came into their visit with a preference for which method they would use. A few patients did not feel comfortable asking the provider about additional methods and as a result were limited in their options.

Most women were particularly concerned about receiving information about side effects. In some cases when patients did not understand or receive such information, they were unsure about starting or continuing a method. One patient expressed the opinion that providers neglect, perhaps deliberately, discussion of potential side effects.

> "I think that they hide the fact of the complications or the defects, the things that might happen if you take that. They don't give you that information and I don't think any provider has given me that information, like really said, 'Okay, you might have spotting.'"

While the content of counseling was important to women, women also had preferences about the format in which information was presented. Many women preferred to get both verbal and written information about contraception in the visit, with many women also indicating comfort with receiving information on the Internet. While women felt that a consultation with a provider was crucial, few participants felt that verbal instruction was sufficient given the quantity of information being provided about different contraceptive methods. Several women said it would be helpful to have material before the visit so they could use it to formulate questions and thought that providers should review it during the visit.

> "Just having some time with … some facts [before the visit] and being able to see a lot of information at once. Because it's hard talking like verbally, unless they were really good at it, getting it down to like, 'What do you really need?' It would be hard to expect every doctor to know how to get that out of a woman."

### 3.5. Social networking

In the process of discussing decision making about contraception, more than half of the participants spontaneously reported the importance of information about the contraceptive experiences and opinions of peers, partners and family members. Influences from these nonmedical sources were more often related to negative opinions of contraceptive methods than to positive ones, and in some cases discouraged patients from trying a method at all. While many of the concerns were medically appropriate, such as those regarding increased risks associated with using oral contraceptive pills over the age of 35 and weight gain with the contraceptive injection, others were based on misinformation, such as concerns about the safety of medically-induced amenorrhea. In the few cases in which women reported talking to their providers about these influences, counseling often failed to address or overcome concerns engendered from these influences, as exemplified by this patient.

**Patient:** I was going to do the IUD but sometimes I heard other women talk about it and I was all like oh, I don't want to try the IUD.

**Interviewer:** What did you hear about it …?

**Patient:** Oh, that they cramp a lot and that they bleed a lot and that sometimes it's uncomfortable and they can feel it.

**Interviewer:** And was that something you talked to her about in your appointment? Did you tell her those things or …?

**Patient:** No, I didn't tell her that. I just told her that, "No, I don't want to do it 'cause I heard things about it."

**Interviewer:** Okay. And was that kind of the end of the conversation or did she ask …?

**Patient:** No, that was the end of the conversation.

### 3.6. Differences by race and ethnicity

While overall there was a high degree of similarity of themes among participants of different race/ethnicities and language, some differences were noted. With respect to language barriers, more Spanish-speaking Latinas reported having trouble understanding and communicating with providers. A higher proportion of Spanish-speaking Latinas mentioned restricted visit time or feeling rushed, and they were less likely to mention that intimacy was important to them in their relationship with family planning providers.

Blacks and Spanish-speaking Latinas were similar to each other, and different from other groups, in several ways. More of these women had decided before their visit which method they wished to use than had white women or English-speaking Latinas, and their method choices were more often based on previous experience and experiences of family members. Women in these same groups were also least likely to desire provider involvement in the decision-making process, and when providers were involved, more women in these groups wanted providers to only share their opinion if a patient asked them or if they clearly explained their rationale. Some of these differences may be related to socioeconomic

differences between these groups, as a lower level of educational attainment was also associated with being more likely to have decided on a method prior to the visit and with being less likely to mention the importance of intimacy in the relationship with the provider, although there was no difference by education in desire for provider involvement.

## 4. Discussion

The goal of this study was to gather women's input about contraceptive counseling in order to help shape future research and programs designed to meet women's needs for quality family planning care. Our results provide guidance for contraceptive counseling research and practice regarding contraceptive decision making, interpersonal relationships and information provision.

While our results regarding decision making agree with the overall desire for autonomy found in other studies [17,19], they also suggest a more nuanced approach to counseling, with more active provider involvement than that represented in the informed choice model of contraceptive decision making. These findings can be understood using the framework for health care decision making proposed by Charles et al. [23], which divides the decision making process into three phases: information sharing, deliberation and decision making. In shared decision making, all three phases are shared between the provider and the patient. In contrast, the informed choice model for contraception involves the provider in only the information-sharing phase, with the patient being responsible for considering her options as they relate to her preferences and making the final decision independently. Our results support a model for contraceptive counseling that is more consistent with shared decision making, in which the provider can be involved, within limits, in the deliberation phase and in some cases even in the decision-making phase.

Given the history of reproductive coercion in some countries and the highly intimate nature of contraceptive decision making, some people may be uncomfortable with this degree of provider involvement. However, this modification of the understanding of contraceptive counseling is clearly aligned with the goals of patient-centered care. Patient-centered care emphasizes attention to the needs and preferences of the individual patient [24]. Therefore, if patients desire provider involvement in the decision-making process, neglecting to provide this decision support is inconsistent with a patient-centered approach.

Our findings also provide some guidance to health care providers who wish to engage in health promotion with their patients to encourage contraceptive use and adherence. While health communication designed to change behavior can be viewed as problematic in the context of this highly personal decision, the finding that provider input was not objectionable when framed in the context of participants' preferences indicates that patient-centered health promotion techniques, such as motivational interviewing [25], may be an appropriate means to promote behavior change in this context. The use of reproductive life plans may be one means to perform this type of counseling [26]. It is important to note, however, that the proposed patient-centered model is distinct from a model, which some have proposed, that emphasizes directive counseling in order to persuade women to use long-acting contraceptive methods [27]. This type of provider involvement, which is not

based on women's preferences, was clearly viewed as problematic by our participants. In addition, one study in the United States found that women who felt pressured into choosing the contraceptive implant were less likely to continue the method [28], indicating this model may be counterproductive. Furthermore, the high rate of uptake of long-acting methods in the Contraceptive Choice Project, which provides nondirective counseling, suggests that increased use of these methods does not depend on the use of persuasion by the counselor, but rather on the provision of adequate information and financial access to the methods [29].

Our findings regarding the desire for intimacy in the patient–provider interaction about contraception are in contradiction to the traditional description of the relationship between doctors and patients, in which emotional detachment and adherence to professional boundaries have been emphasized [30,31]. However, over the past few decades, there has been increasing discussion of the role of empathy in the clinical encounter and the balance between effective emotional engagement with patients, clinical objectivity and respect for patient autonomy [32–35]. Our study suggests that, in the area of family planning, with a young patient population relative to many areas of health care and the need for consideration of personal and sensitive issues, some patients may be particularly interested in personal engagement with their health care providers. Continuity of care may be one way to provide patients with the desired sense of comfort when discussing intimate issues.

The desire by our participants for adequate information provision is consistent with previous studies [35]. Our finding that women specifically want, and are concerned that providers will not give, information about side effects indicates the importance of providers explicitly discussing side effects known to be associated with contraceptive methods, such as changes in menstrual patterns for progestin-only methods. Evidence that discussion of negative side effects does not affect patient adherence, and may in fact be beneficial, supports this practice [36–39]. With respect to possible side effects for which there is no epidemiological evidence of association with contraceptive methods, we acknowledge the concern by some authors that counseling about these issues may be unnecessary or even harmful due to a nocebo effect [40]. However, our results suggest that providers should inquire about whether women have specific concerns about other side effects in order to ensure that women feel their concerns are addressed. Failure to do so or doing so in a dismissive manner that does not acknowledge the range of possible experiences may interfere with women's trust in the counseling provided.

One important consideration regarding our findings about contraceptive decision making, intimacy and information provision is the presence of variability in preferences. This is particularly relevant given the differences by race, ethnicity and language identified in our study. Family planning providers must be attuned to differences both between and within groups in order to meet the needs of their individual patients. The most direct way to accomplish this is to explicitly ask patients about their preferences and goals for care.

An additional finding from our study that merits discussion is women's reliance on outside sources of information when considering their contraceptive choices. It may be useful to explore how providers can engage with patients about these influences. Directly addressing the influence of social networks on contraceptive attitudes and behavior has the potential to

minimize inappropriate concerns and misinformation. In addition, encouraging women to discuss their contraceptive use with supportive peers may improve the motivation to use contraception, as one study has shown that women were more likely to have consistent condom use with their partners if they frequently discussed birth control with their girlfriends and mothers [8].

A few limitations of this study should be mentioned. The first is that our study was exclusively conducted in the United States. Therefore, our findings regarding counseling preferences may not be applicable to other settings, particularly those with different cultural expectations around medical care and gender relations. In addition, comparison of groups in a qualitative study poses additional challenges and can be considered only hypothesis-generating, especially given the differences in age and education in the racial/ethnic/language groups in our sample. As noted, some of the differences in counseling preferences we identified may be related to socioeconomic differences between the racial/ethnic groups included in this study. We also note that there was also substantial variation within each group, which underlines the importance of providing individualized counseling and not overgeneralizing based on these results. Finally, as our results are inherently subjective, objective assessment of visit content would be useful in assessing women's experiences of counseling and how the way in which information and advice are presented affects decision making about contraceptives and their subsequent use.

## 5. Conclusion

Many patients desire active involvement of their family planning provider during the process of choosing a contraceptive method, and value intimacy and adequate information provision during the contraceptive counseling encounter. In order to accommodate a range of patient experience and desires, it is valuable for providers to adopt a patient-centered approach to counseling in which patient preferences are explicitly discussed and attended to.

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**Table 1**

Participant characteristics

| | **Total population (%)** | **Non-Hispanic white (%)** | **Black (%)** | **Latina Spanish-speaking (%)** | **Latina English-speaking (%)** |
|---|---|---|---|---|---|
| Total, *n* (%) | 42 (100) | 10 (100) | 10 (100) | 13 (100) | 9 (100) |
| Age mean (range) | 28 (19–46) | 30 (21–39) | 25 (19–38) | 27 (21–46) | 31 (20–39) |
| Education, *n* (%) | | | | | |
| Less than high school | 9 (21) | 2 (20) | 2 (20) | 3 (23) | 2 (22) |
| High school | 11 (26) | 1 (10) | 3 (30) | 5 (38) | 2 (22) |
| 4-year college | 14 (33) | 1 (10) | 5 (50) | 5 (38) | 3 (33) |
| More than 4-year college | 8 (19) | 6 (60) | 0 (0%) | 0 (0) | 2 (22) |
| Parity, *n* (%) | | | | | |
| Nulliparous | 15 (36) | 7 (70) | 2 (20) | 2 (15) | 4 (44) |
| Parous | 27 (64) | 3 (30) | 8 (80) | 11 (85) | 5 (56) |
| Previous contraceptive methods used, mean (range) | 3 (1–5) | 3 (1–5) | 3 (1–5) | 3 (2–4) | 4 (2–5) |