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Young Women's Perspectives About the Contraceptive Counseling Received During Their Emergency Contraception Visit

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A B S T R A C T

Objectives: Research aimed at understanding women's experiences accessing emergency contraception (EC) services and the extent to which providers support women's autonomous contraceptive decision making is limited. This study explores young women's experiences with contraceptive counseling when accessing EC at family planning specialty clinics that serve young adult and adolescent patients.

Methods: We conducted 22 in-depth telephone interviews with women ages 15–25 years who had recently accessed EC at two San Francisco Bay Area youth-serving clinics about their thoughts and experiences using and accessing contraception. We analyzed transcripts thematically, using inductive qualitative analytic methods to identify patterns across the interviews.

Results: Most respondents described their recent clinic visit to access EC positively. Specifically, they expressed appreciation about receiving comprehensive information about other methods of contraception without pressure, judgment, or the expectation that they adopt a particular method. They also pointed to the influence of prior health care experiences in which they felt pressured or judged, leading them to avoid accessing future reproductive health services.

Conclusions: We found that young women seeking EC appreciated learning about other contraceptive methods, but do not want to feel pressured to adopt a method in addition to EC. Findings highlight the importance of respecting young women's contraceptive decisions for building and maintaining provider trust and suggest that contraceptive counseling approaches that prioritize specific methods may reduce some young women's trust in providers and use of reproductive health services.

The Centers for Disease Control and Prevention recommend that contraceptive counseling include general information about the efficacy and side effects of methods and that it address individual patient preferences and concerns (Gavin et al., 2014; Klein, Arnold, & Reese, 2015). Adolescent health specialty providers and researchers consider counseling of young women to be particularly complex (Potter & Santelli, 2015). In addition to ensuring confidentiality and establishing positive rapport and trust, providers must consider adolescents' unique developmental stage and capacity to weigh the risks and benefits of various contraceptive options, recent initiation of sexual activity, social influences, and the financial and logistical barriers to accessing care (Potter & Santelli, 2015; Raidoo & Kaneshiro, 2017). Owing to adolescents' high risk for unintended pregnancy, both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (ACOG) recommend a tiered-effectiveness approach when discussing contraception with adolescents, whereby providers begin first with information about the methods most effective at

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preventing pregnancy—intrauterine devices (IUDs) and contraceptive implants (ACOG, 2017; Eliscu & Burstein, 2016). Yet, we do not know how young women experience such an approach and whether it addresses their preferences in choosing a contraceptive method.

One potentially unique setting for contraceptive counseling of young women is a visit for emergency contraception (EC). Women in the United States have access to four forms of EC: the copper IUD, which is placed by a clinician; three oral forms of EC—ulipristal acetate, available by prescription; levonorgestrel, available without prescription; and the Yuzpe regimen, which involves combined oral contraceptive pill products (Batur, Kransdorf, & Casey, 2016; Cleland, Raymond, Westley, & Trussell, 2014). Health care visits in which women are seeking EC have unique elements that may affect providers' approach to counseling. Most women who use EC pills are young adults or adolescents, and have recently had unprotected sex or experienced a method failure (Daniels, Jones, & Abma, 2013). Providers often see the EC visit as an opportunity to encourage women to use or initiate a contraceptive method in addition to EC, and more recently, to increase awareness about the availability of the IUD as EC and as an ongoing method (ACOG, 2015; Falk, Falk, Hanson, & Milsom, 2001; Lee, Papic, Baldauf, Updike, & Schwarz, 2015; Schwarz et al., 2014). Providers may view the EC visit as a chance to offer women these additional counseling services beyond what they would receive through pharmacy provision of EC.

Little research has investigated what young women desire from contraceptive counseling. The limited available research indicates that young women prefer patient-centered approaches and counseling tailored to address their specific contraceptive needs (Brown, Auerswald, Eyre, Deardorff, & Dehlendorf, 2013; Rubin, Felsher, Korich, & Jacobs, 2016). Across age groups, women report that autonomy in their contraceptive decisions is particularly important, even more so than for decisions about other aspects of their health care (Dehlendorf, Diedrich, Drey, Postone, & Steinauer, 2010). Yet, there has been limited research into the experiences of young women and the extent to which they feel that providers support autonomous contraceptive decision making. Through in-depth interviews, this study explores young women's counseling experiences when accessing EC at family planning specialty clinics. Specifically, this study looks at the elements of contraceptive counseling that women appreciated, as well as those they disliked, during their EC visit.

Methods

Respondent Recruitment

From July to November 2016, we recruited women accessing EC at two San Francisco Bay Area youth-serving clinics to participate in an in-depth telephone interview regarding their clinic visit and experiences accessing and using contraception. The recruitment clinics serve primarily Latino/a and African American populations and offer a full range of contraceptive methods, including IUDs and implants, to low-income and adolescent patients at no charge through California's state family planning program. Patients ages 30 and younger and seeking EC were eligible to participate. Parental consent was not required for minors, because they can consent to contraceptive services in California. After the EC visit, the onsite research coordinator informed patients about the study by giving them a study flier and then screened interested patients for eligibility. The research coordinator completed verbal consent with eligible and interested women and handed them an iPad where the respondent could privately enter her contact information into a secure web-based form. Our research staff received the respondent contact information in real time and, within 2 days, scheduled a telephone interview with one of two female interviewers, both fluent in English and Spanish. One of the interviewers was non-Hispanic White and the other was Hispanic White. Both interviewers were trained in conducting in-depth interviews and had extensive experience studying and interviewing women, including adolescents, regarding their sexual and reproductive health. Interviewers used a feminist research methodology in conducting the interviews (Hesse-Biber, 2011), centering the experiences of respondents, allowing respondents to guide the interview flow based on what was salient to them, and, in the form of regular team meetings, reflecting on how their social locations impacted the interviews and subsequent analysis. We aimed to recruit a minimum of 20 women, a figure we deemed feasible given the clinics' EC patient volume and appropriate given the exploratory nature of the study. We interviewed respondents by telephone in the language of their choice, English or Spanish, up to 1 month after their EC visit. We established this recruitment timeframe because we felt it enabled researchers to best accommodate potential respondents' schedules and availability, especially those who had limited free time or needed to plan a time and location to ensure their privacy. Also, this timeframe allowed for some perspective about the visit without allowing so much time that their memories of the visit would be compromised. We offered respondents a $25 gift card to thank them for their time. We audio-recorded all interviews and transcribed them verbatim. After each interview, the interviewer summarized their reflections and salient points about the interview in a brief memo. Only one respondent chose to be interviewed in Spanish. A certified translator transcribed and translated this one interview into English. The University of California, San Francisco (UCSF), Institutional Review Board approved the study protocol.

We used an open-ended interview guide with domains for respondents' experiences with and reasons for choosing less effective methods (e.g., condoms, withdrawal, and EC); perceived risks and benefits of using contraception and becoming pregnant; and experiences with the clinic visit, including whether they were offered ongoing contraceptive methods and how they felt about any contraceptive counseling they received. The interviews themselves were semistructured, allowing participants to share their thoughts and experiences with contraception and the clinic visit and to introduce new ideas in a way that made sense to them. Interviewers did not always follow the order of the interview guide, but they did ensure that they discussed all domains at some point in the interview. The interviews averaged 35 minutes in length.

Analysis

We used an inductive thematic approach to analysis (Gibbs, 2007; Guest, MacQueen, & Namey, 2011). M.A.B., who is trained in social psychology, and N.B., who is trained in public health, led the analysis. After reviewing an initial set of interview transcripts, they independently generated initial lists of thematic codes, including both a priori codes developed from the interview topics and emergent codes that arose from reviewing the transcripts (Gibbs, 2007). M.A.B. and N.B. discussed their independent lists of codes with K.K., a qualitative sociologist, and we

collectively developed several analytical codes relevant to our research question. To develop a final code list, we wrote code descriptions detailing the nature and thinking behind each code to ensure that we applied all codes consistently, revising the code list and descriptions iteratively after discussion until we reached consensus. When the code list was finalized, M.A.B. and N.B. coded all transcribed interviews in Dedoose (2013). After coding all transcripts, we summarized emergent themes into memos. The authors met regularly to discuss and synthesize memos. This article summarizes patients' reflections about the contraceptive counseling they received during their current EC visit, as well as their previous experiences accessing health care. We use pseudonyms in our presentation of quotes to protect participant confidentiality.

Results

We first present characteristics of the sample. We then present the salient themes related to respondents' experiences of contraceptive counseling that emerged from the interviews, which included their positive experiences of receiving comprehensive contraceptive information without pressure to use or the expectation to choose a particular ongoing method, and the influence of prior health care experiences and expectations on their reproductive health service seeking and current visit experiences.

Respondent Characteristics

We conducted 22 in-depth telephone interviews with women ages 15 to 25 (Table 1). Consistent with the populations these clinics serve, 50% of respondents identified as Latina and 23% as African American. Most women had previously used EC pills and a range of other methods; eight had a history of pregnancy.

Table 1
Sample Description

	N	%
Age, y (mean ± standard deviation)	20.8 ± 2.8	
Race/ethnicity		
African American	5	23
Asian	1	5
Latina	11	50
More than one race	3	14
Missing	2	9
Highest level of education		
Some high school	5	23
High school diploma/GED	3	14
Some community college or technical school	5	23
Some college	5	23
College degree	2	9
Missing	2	9
Methods received at the clinic visit		
EC pills only	9	41
Copper IUD as EC	3	14
EC pills and additional method*	10	45
Ever used EC before	17	85
Ever been pregnant	8	36
Ever had abortion	4	18
Ever given birth	3	14

Abbreviations: EC, Emergency contraception; IUD, intrauterine device.
Demographic data were incomplete for two interviews that were cut short owing to respondent time constraints.

* Additional methods included the hormonal IUD ($n = 4$), condoms ($n = 4$), contraceptive implant ($n = 3$), injections ($n = 2$), and oral contraceptive pills ($n = 1$).

Sharing of Options and Information Without Expectations, Pressure, or Judgment

Across interviews, women reported a strong sense of connection, comfort, and support from their provider during their visit and nearly all described their recent clinic visit favorably. Some respondents attributed their positive visit experiences to how they were informed about available contraceptive options. In particular, they noted that this information was shared by clinicians without the expectation that they adopt a particular contraceptive method. For example, Allison, an 18-year-old who chose EC pills because that is, "what women usually resort to after having unprotected sex," described her visit favorably because she perceived that her provider did not expect her to choose an additional method. She sought EC after recently having unprotected sex with a casual partner and had no immediate plans to have sex again. Allison offered several reasons why she chose EC pills and not an additional method, including because "I'm not sexually active," having experienced negative side effects when using oral contraceptive pills, and because she "didn't feel comfortable with the thing [implant] in me." In describing her visit experience, Allison highlighted positively how the staff did not have specific expectations of her choosing an ongoing method: "They definitely weren't pushy about having one method over another…. They weren't like that. They were just very informative and they let me know about all my options." Another woman, Charleen, reported being pleased that clinic staff did not judge her for preferring condoms over other, more effective methods: "[The visit] was nice.... The doctor, when she came in, she was cool. She reminded me about birth control, but she was telling me I was doing good with just … using condoms." Charleen viewed prescribed contraceptive methods but not condoms or EC pills as "birth control" and appreciated how the provider respected her preference for condoms.

The importance to respondents of not feeling pressured or expected by their provider to use a specific method was a theme across several respondents who left with EC pills and no additional method of contraception. For example, Dorean, a 22-year-old respondent who left her visit with only EC pills described her visit "From a one to a ten, it was a ten…. They weren't pushing me to get on birth control, [and] that's what I liked." She went on to explain how "normally they give all these suggestions and advice as to why I should get on birth control and then also they give all these different ways.... Like you can get it in the arm, you can take the pill." Dorean's experience was not unique. Dawn, age 25, who had recently had the IUD removed, chose EC pills and no other method at this visit because she wanted to "take a break [from contraception]…. It's been literally 7 years I've been on birth control … and I just didn't want to get right back on it." When asked about any experiences of feeling judged during her visit, Dawn responded "Not at all. I'm very comfortable there." She elaborated on how she appreciated receiving information to take home to inform her future contraceptive decision making. She said, "I'm still interested in birth control.… I just needed some time to think to myself and go over my options.... Every time I go to the clinic there, I always have plenty of options. And they're actually really great ones. [The clinic staff] make me feel better about any decision I would ever want to make." In her

explanation, Dawn linked her experience of not being judged for wanting to wait before adopting another contraceptive method to trusting her provider and her willingness to return for care there in the future. Neither of these women considered their use of EC pills as "being on birth control" and both articulated appreciation of clinic staff for supporting their desire to forgo an additional contraceptive method at that time.

Respondents who chose a method in addition to EC also attributed their positive visit experiences to the provider's absence of judgment of their sexual behaviors and lack of expectations that they adopt a particular method. Martina adopted the implant because she wanted to avoid needing EC again, perceived the provider to be "comfortable with whatever I chose.… She made me feel really comfortable.… [She said] 'These things [unprotected sex] happen. It's okay.'" Carla, who chose the hormonal IUD in addition to EC pills, recounted that she was happy to hear about different options, while not being expected to adopt a particular method: "I already knew I wanted the Mirena, I was set on that…. They were not set on anything. So I listened to the other [contraceptive] options they gave me but I wasn't really interested. They were just opening up and giving more options." Similarly, Gretta, age 19, left her visit with the copper IUD and condoms. Gretta explained how she appreciated being offered methods without pressure: "They were like, 'Well, you come a little more regularly [to the clinic], and you're usually here for a pregnancy test. So let's just nip that in the bud.'… I felt like it was very nice of her. I didn't feel pressured, but I definitely felt like they were just trying to look out for me…. I didn't feel judged."

Although respondents spoke of how they appreciated being informed about methods, they also pointed to the importance of receiving guidance from their provider. Moyra, age 20, described how the receipt of information about contraception without pressure influenced her desire to adopt the contraceptive implant. She said,

> At first, I didn't [want a method] because I'm not seeing anybody, but then they were nice. They were just like "oh you don't have to do [this], but here are these options" and they were explaining it and it kind of made me think. They were not forcing me; it kind of made me think. Just in case, so another accident doesn't happen like that. They were explaining it and I [thought] "okay, I guess they have a point."

For Moyra, the sharing of information in a noncoercive manner seemed to affect her willingness to consider the information offered, suggesting that it helped to build her trust in the provider.

Several respondents appreciated when providers considered their contraceptive preferences. Isabel learned about and chose a hormonal IUD at her visit. When she contemplated whether the provider considered her preferences she responded, "Oh yes. Definitely. Other people probably would have just been like, 'You should take this one since it's easier,' but since I told her my problem [heavy periods and cramping], she was really helpful with that."

Nonetheless, respondents made clear that there was a distinction between guidance and pressure—and they did not want to feel pressured to choose a method of contraception in addition to EC pills. This experience of pressure, although rare in our sample, led to the only expressions of visit dissatisfaction. The experience of 25-year-old Alisa is illustrative. Alisa relayed that she felt the clinic staff were too aggressive and did not respect her decision to choose EC pills only: "[The clinic] was a little bit pushy, to grab any birth control." When asked whether she felt the provider wanted her to choose a particular method, Alisa responded:

> Yeah. Any method. And I'm familiar with all of them already … and it's not something I wanted to re-hear again. If I wanted to get birth control I would have done it a while ago. It was more like pushy to do it. I don't know if they want all the girls on birth control. I don't know what's going on with the population or what. … I was in and out with the Plan B [EC pills] but then they kind of held me there for the birth control.

Alisa considered herself already informed about her contraceptive options and self-efficacious enough to use contraception if that was something she wanted. Her comment, too, points to Alisa's broader perspective that the counseling she received was not tailored to her needs and preferences, but more generally motivated by providers' desire to have "all the girls on birth control." Altogether, this led Alisa to express overall dissatisfaction with her EC visit.

Influence of Prior Health Care Experiences

Across interviews, respondents talked favorably about how the counseling they received made them more likely to return for future contraceptive care. Their accounts of past contraceptive counseling experiences further underscored how individual health care experiences do not exist in a vacuum. Some respondents described health care experiences at other clinics that were negative and thus compromised their trust in providers. In some of these experiences respondents described feeling judged, uninformed, misinformed, embarrassed, or that a contraceptive method was "pushed on" them. Charleen described a previous contraceptive counseling experience where she felt the counseling was not tailored to her needs and that the clinician's claims were untrue: "They say [these methods] prevent pregnancy and everything, but I wasn't having sex at the time. Then I was told [by the clinician] it was supposed to help clear my skin acne, and I still have acne." That experience was in contrast with Charleen's current visit, which she described favorably: "It was nice … the lady that I was talking to … was really cool and nice … and the front desk guys, they were nice, and the doctor, when she came in, she was cool. She asked me what different kind of birth controls [had] I used, and I [had] used almost every one, and I didn't like them now." When asked whether she felt pressured to adopt a contraceptive method at the current visit, Charleen responded, "No, not really. I know they want people to be on birth control in my age group, but, no." In essence, Charleen recognized that the providers had a desire for young women to "be on birth control," but still felt the counseling she received was respectful of her preferences.

In some cases, prior negative experiences affected women's subsequent health care-seeking behavior. Dawn described a series of previous experiences when she felt her providers did not listen to her:

> The first time [I visited a different clinic] I'm like, okay, well I'm young…. And then, the second time I just felt like: you guys are just being rude…. And then, the third time it was like, "Is it me as a person or are you just cranky?" After that, I just said, "You know what?... You guys are still not answering the questions I really wanted to know when it came to birth control" … And it made me never want to go to another clinic.

These negative experiences had consequences. Dawn did not seek contraceptive services for a full year and a half after her third negative experience, despite desiring to prevent pregnancy, and she felt a great deal of shame and secrecy around her use of contraception. At the current clinic, however, "It was a whole different ballpark. I was very comfortable. I was able to talk and know that they are listening because when I say something they had an answer for me. That is what I was looking for."

Similarly, Karina, age 19, described not wanting to return for care owing to prior experiences where she felt embarrassed and judged for being a teen parent and for wanting to remove the contraceptive implant owing to side effects:

> I didn't go back to the doctor because they were like, "Why do you want to take it [implant] off? Is it that you want to have a kid?" I didn't feel comfortable going back, so I didn't go back.

Karina then described her surprise about the absence of judgment she received at her current visit.

> It was kind of refreshing for me because when somebody hears... you're 19 and… have two kids, they're like, "What!" [The current visit] was totally different. She didn't give me that judgmental talk."

Karina then explained how at the current visit, the providers' reassurance that they would remove the IUD whenever she wanted to influenced her decision to choose it.

Discussion

In this study of women accessing EC at two youth-serving clinics, we found that young women valued the contraceptive counseling they received when they did not feel judged or pressured to use certain methods and received guidance in selecting a method, if they wanted one. Respondents indicated surprise, relief, and high satisfaction with the visit when they felt the provider did not have a predetermined method in mind and offered methods without pressure. Most of the young women were pleased with their EC visit because they felt that they could make their own contraceptive decisions, and perceived the clinic staff not to be "too pushy." These emergent findings are consistent with a growing body of evidence suggesting that patient-centered counseling approaches are associated with contraceptive continuation, use of more effective contraceptive methods, and greater method satisfaction (Dehlendorf, Grumbach, Schmittdiel, & Steinauer, 2017; Dehlendorf et al., 2016; Schivone & Glish, 2017).

Many respondents articulated concerns about feeling pressured by their provider to use a method. Women who did not desire an ongoing contraceptive method thus appreciated when they did not feel pressured to adopt a method or a particular method and were disappointed when clinic staff did not seem to respect their preferences. Patients' experiences and concerns about "pushiness" have previously been described in the literature as a feeling of "implicit pressure," where patients perceive the provider has a goal that she leave with a particular contraceptive method (Gomez & Wapman, 2017). We find that, for some women, being in a clinic environment that ensured autonomous decision making and was not "pushy" came as a welcomed surprise.

Previous research indicates that patients are more likely to return for care if providers consider their preferences (Amico, Bennett, Karasz, & Gold, 2016; Dehlendorf et al., 2010). Respondents who described experiencing implicit pressure in past health care visits reported that it impacted their subsequent health care use; specifically, we found women who felt judged during a previous contraceptive health care interaction refrained from accessing contraceptive services subsequently, despite a desire to prevent pregnancy. This finding is consistent with a qualitative study of a community-based sample of young women that found that experiences of implicit pressure during contraceptive counseling negatively affected future health care-seeking behavior (Gomez & Wapman, 2017).

Our findings are also consistent with research arguing for the benefits of counseling approaches that consider the range of attributes women value in choosing a method, as well as women's varied and well-considered reasons for preferring less effective methods, even when pregnancy prevention is the goal (Lessard et al., 2012; Madden, Secura, Nease, Politi, & Peipert, 2015). Counseling that emphasizes certain contraceptive characteristics over autonomy runs the risk of relaying to the patient that the provider has preset views of the preferred method for the patient, potentially dismissing patient preferences. A better understanding of how tiered contraceptive counseling, where the most effective methods are mentioned before any others, affects the quality of the visit experience, would be useful, particularly because this approach is widely recommended and used in practice (Birgisson, Zhao, Secura, Madden, & Peipert, 2015; Klein et al., 2015; Stanback, Steiner, Dorflinger, Solo, & Cates, 2015).

This study has important strengths. We took special steps to ensure the confirmability of our research findings by meeting regularly among our co-authors to develop, discuss, and finalize codes and memos. We also created detailed descriptions of each code to ensure that we applied codes consistently. Another notable strength is that we captured the voices of young women accessing EC services in settings where a full range of contraceptive methods is available at no cost. Clinicians have conceptualized this population as distinct and in need of specific counseling, but our data suggest they want and appreciate the same elements of counseling that research on general contraceptive counseling has identified. Thus, our findings are potentially transferable to other types of contraceptive counseling visits.

This study also has important limitations. Our findings are limited by geography and may be affected by the design of recruiting women at youth-friendly clinics. Notably, women's experiences with their current visit were mostly positive. Women from other clinic settings may have more varied experiences with providers, and thus our findings are not necessarily transferable to other settings. Furthermore, we recruited our sample from clinics that serve mostly Latina and African American youth from low-income backgrounds. As such, it centers a population often overlooked in research or studied only after research on racial majority populations, but its findings may not be transferable to youth from other race and class backgrounds. This is particularly likely as evidence from another qualitative study suggests that African American and Latina women may be less likely than White women to desire provider involvement in their decision making around contraception (Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013).

Our findings highlight the importance of respecting women's decisions, regardless of whether their decision involves adopting or forgoing contraceptive methods, in order to build and maintain provider trust. Public health goals to prevent unintended pregnancy are best achieved when autonomous decision making is fostered. Patient-centered contraceptive counseling approaches in the EC visit can decrease the likelihood of women

feeling pressured to use certain methods, to support future health-seeking behavior, and to foster a positive connection with the health care system.

Implications for Practice and/or Policy

We find that young women prefer contraceptive counseling that is supportive of their autonomous decision making and offers guidance while addressing their preferences. Practitioners should consider women's desire for supportive guidance, autonomous decision making, and counseling that addresses their preferences in their contraceptive counseling.

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