Contraceptive Counseling: The Patient Interview

Contraceptive counseling is a process that continues throughout the fertile period of a woman’s life – from menarche to menopause. Each patient visit should, therefore, include a discussion of her satisfaction with her current contraceptive and her future contraception needs.

This talk provides an overview of the major elements in the patient interview when contraception is discussed. It can be combined with other talks in the Contraception Online Slide Library for a comprehensive talk on a specific contraceptive method.

The Patient Interview: The Clinician’s Priorities

- Recognize the patient’s goals for control of fertility
- Identify the patient’s health risks that result in some methods being preferred over others
- Determine the patient’s ability to consistently and correctly use the preferred method

The Patient Interview: The Clinician’s Priorities

A female’s age, near-term or long-term desire for children, and sexual activity are important determinants of her contraceptive goals. Her risk for sexually transmitted infections, as well as her family history and personal health risks (e.g., cardiovascular disease; cancer), are important considerations in choosing the type of method that is appropriate for her. And, finally, the
patient’s comprehension of the mechanisms of action of a contraceptive, the level of self-discipline required to use it, and any cultural or moral concerns will influence her ability to consistently and correctly use the method she chooses.

The Patient’s Goals for Fertility Control
A woman’s fertility lasts for nearly 40 years of her life. Although no one pattern of needs fits all women, this chart illustrates how those needs can change over time – shifting from a desire to avoid being pregnant to a desire for spacing her pregnancies, and then back again. Depending on her desires for pregnancy spacing or avoidance, the characteristics of the contraceptive method a woman needs may also change.

Reference:
Contraceptive Failure Rates Within the First Year With Typical Use
This table shows the percentage of women who will experience an unintended pregnancy within the first year when using a given method under typical conditions. Efficacy is lowest for non-hormonal methods that are coitally dependent. Efficacy improves with correct and consistent use and when 2 methods (e.g., a barrier method and a hormonal method) are used simultaneously.

Reference:

Teaching Patients About Contraceptive Efficacy
Patients should be aware that the efficacy of a contraceptive depends on its correct and consistent use. They should also know that even the most efficacious method may fail, even with appropriate use. Patients should be counseled about the comparable efficacy rates of contraceptive methods with typical use and helped to understand that long-term methods (e.g., injectable contraceptives; intrauterine devices) tend to have greater efficacy and lower failure (i.e., pregnancy) rates. Overall, the efficacy of a given contraceptive method can be increased by using it simultaneously with another. Finally, patients should understand the principles of emergency contraception as the last opportunity to prevent pregnancy and understand how to obtain it. For women under the age of 18 years, a prescription should be provided for emergency contraception, especially if they are using a barrier method or a cyclic method of contraception (i.e., oral contraceptives, the patch, the vaginal ring, or an injectable contraceptive).
Protecting Future Fertility

Patients are often concerned about their future fertility after using a contraceptive. The time of return to fertility varies among women and is primarily related to the length of time it takes for contraceptive hormones to be cleared from the body.

Abstinence is the best way to preserving fertility. Since sexually transmitted infections can compromise fertility, women at high risk for these infections, such as women who have multiple sexual partners, should always be counseled to use a barrier method (i.e., a condom) in addition to their preferred method of contraception.

A study by the Oxford Planning Association Study demonstrated the conception rates of more than 17,000 women between the ages of 25 and 39 years who stopped using a contraceptive to plan a pregnancy. All the contraceptive methods used by the study participants were associated with a decreased rate of pregnancy after 12 months. When the use of a contraceptive was halted, the conception rate reached approximately 80% by 18 months for all women and for all contraceptive methods. If a women desires to become pregnant immediately after receiving an injection of depot-medroxyprogesterone acetate, she will have to wait at least 3 months for the hormone to be cleared. While the intrauterine device and contraceptive implant offer a rapid return to fertility, both require a visit to a health-care professional for removal.

References:


Patient Health Risks: Serious Adverse Events

Serious adverse events influence clinicians’ selection of an appropriate method of contraception. The World Health Organization (WHO) lists medical conditions that represent an unacceptable health risk (category 4) for specific contraceptive methods. For example, breast cancer is listed as a category 4 risk for all contraceptive methods except the copper intrauterine device (IUD). Below is a summary of the unacceptable risks for which combined contraceptives or the IUD are considered to be unacceptable health risks. Refer to the WHO Medical Eligibility Criteria for individual methods for a comprehensive review of conditions.

Taking combination contraceptives – pills, the patch, or the vaginal ring – are considered to be unacceptable health risks for women who are <6 weeks postpartum and breastfeeding. Other women at risk are those who have arterial cardiovascular disease; vascular disease; elevated blood pressures (>160 mm Hg systolic/>100 mm Hg diastolic); a current deep vein thrombosis or pulmonary embolism or history thereof; or a history of ischemic heart disease, stroke, valvular heart disease, or diabetes with related eye, liver or nerve diseases. Women who smoke ≥15 cigarettes/day, who have headaches with auras, and who have severe cirrhosis, active viral hepatitis, or liver tumors are also considered to have unacceptable health risks for combined contraceptives.

As with other methods of hormonal contraception, some users of the Ortho Evra® transdermal patch have had venous thromboembolic events. Although it has been hypothesized that the patch confers an increased risk of these events because it contains a greater amount of estradiol than other hormonal contraceptive methods, studies of transdermal patch usage and risk of venous thromboembolic events have given conflicting results.

Finally, bone mineral density decreases have been documented with the use of injectable contraceptives; some but not complete recovery of bone mineral density has been documented after discontinuation. The United States Food and Drug Administration has issued a warning that a woman should use Depo-Provera® (depot-medroxyprogesterone acetate) for more than 2 years only if other contraceptive methods are inadequate for her. Furthermore, the Society for Adolescent Medicine has provided guidelines for clinicians who prescribe depot-medroxyprogesterone acetate for their adolescent patients.

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Contraceptive Methods and Cancer Risk

One of the misconceptions about hormonal contraceptives is that they cause cancer. In fact, many women and clinicians are not aware that some hormonal contraceptives provide protection against gynecological cancer.

Large case-control studies have demonstrated that oral contraceptive use is associated with a decreased risk of cervical, ovarian, and uterine cancer. Data on the risk of breast cancer with oral contraceptive use are conflicting. Analyses indicate a slight increased risk of breast cancer with oral contraceptive use, whereas a case-control study conducted in several cities in the United States found no increased risk in current or former users. There are no data regarding the effects of the contraceptive patch and vaginal ring on cancer. Overall, risks associated with these methods are expected to be comparable to other methods that contain similar hormones; however, patch users are exposed to increased levels of estrogen when compared to oral contraceptive users.
Barrier methods, such as the condom or diaphragm, protect against cervical cancer, most likely because they block infection from penetrating the cervix.

Small case-control studies indicate that use of injectable depot-medroxyprogesterone acetate is associated with protection against uterine cancer and without an increased risk of cervical cancer.

Copper intrauterine devices and the levonorgestrel-releasing intrauterine system are associated with a decreased risk of cervical and endometrial cancer.

Tubal sterilization is associated with a decreased risk of cervical, uterine, and ovarian cancer.

Abstinence prevents exposure to the human papillomavirus, thereby decreasing the risk of cervical cancer.

For additional information, please see “Gynecologic and Colorectal Cancer: Risks and Benefits of Contraceptive Methods,” a talk in the Contraception Online slide library.

References:


Kjaer SK, Mellemkjaer L, Brinton LA, Johansen C, Gridley G, Olsen JH. Tubal sterilization and

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**Patient Barriers to Consistent and Correct Use of a Contraceptive Method**

- Experience with the method
- Fears and misunderstandings
- Ability to remember and use the method
- Tolerance of side effects
- Cultural, social, or moral concerns
- Partner (or parental) objections

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**Improving a Patient’s Experience With a Contraceptive Method**

- Involve her in her education. Have her:
  - Handle the method she is considering
  - Restate what she heard you say
  - Practice conversations she may have with others
- Use Quick Start whenever possible
- Give her permission to make another choice if her first choice does not work
- Use patient handouts to summarize your messages
- Encourage her to call if she has questions or concerns

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**Improving A Patient’s Experience With a Contraceptive Method**

Patients who do not have experience with a given contraceptive method can nonetheless use it successfully.

Patients should always be encouraged to participate in the learning process by handling the contraceptive medications and devices, restating instructions for their use in their own words, and...
practicing conversations that they may need to have with their parent(s) or partner(s).

Whenever possible, the Quick Start method should be employed. Quick Start initiates the contraceptive method during the clinic visit and has been proven to be a more effective technique for getting a woman to start contraception than, for example, the Sunday-start strategy which is typically used for initiation for oral contraceptives. Methods that require informed consent or a negative pregnancy test, are not conducive to Quick Start.

The discussion of contraceptive methods should allow the patient to identify acceptable alternative methods if possible and to leave the clinic believing that if she cannot be successful with her chosen method that she has other options. This strategy can ensure that she will be able to use the contraceptive successfully and will feel free to return to the clinic if she desires a different method.

Patient information sheets should discuss the efficacy of the method and its possible side effects and potential risks. It should also describe how the method should be used consistently, what the patient should do if she has forgotten to use the method or has used it incorrectly; and how to contact the clinic or office if she has questions or needs a refill.

Reference:

Myths and Misconceptions About Contraceptives
This slide lists several of the myths and misconceptions that prevent women from using oral contraceptives, condoms, and contraceptive injections.

The low-dose oral contraceptives available today are not associated with an increased risk of cancer or of blood clots, except in rare instances. Women are more susceptible to blood clots should not use oral contraceptives. Some women may experience weight gain from the use of oral contraceptives and other hormonal methods. Switching to another oral contraceptive and implementing a regimen of diet and exercise can minimize the amount of weight gained. Women over 35 years of age who do not smoke or do not have risk factors for heart attack or stroke can
safely use the newer formulations of oral contraceptives. Some women believe that they need to periodically stop taking oral contraceptives because they “build up in the body.”

Some women who use the injectable contraceptive depot-medroxyprogesterone acetate may experience a delay in becoming pregnant; clinical data indicate that the average delay is 6 months following the last injection. Since an injection is expected to be effective for 13 weeks, such a delay would not be unreasonable. For women who are interested in becoming pregnant in the near term, this method of contraception would not be appropriate. It does not cause infertility with either short- or long-term use.

Common myths associated with the condom are also listed on this slide.

Myths and Misconceptions Regarding Intrauterine Contraceptives (IUDs)

There are a number of myths and inaccuracies about intrauterine devices (IUDs). These are listed in this slide.

Patients who are considering an IUD as their contraception should be told:

- IUDs are not abortifacients; their primary mechanism of action is to prevent fertilization.
- IUDs do not increase the risk of ectopic pregnancy but are highly effective in preventing all types of pregnancy. Should a pregnancy occur, it is more likely to be ectopic than intrauterine. Although IUD use in women with a previous ectopic pregnancy is appropriate, this is an off-label use. According to the Medical Eligibility Criteria for Contraceptive Use developed by the World Health Organization (WHO), a previous ectopic pregnancy is a condition for which there are no restrictions (risk category 1).
- IUDs do not increase the risk of pelvic inflammatory disease (PID), but PID can occur within the first 20 days after insertion. For this reason, patients should be evaluated for the presence of infection, as well as for proper IUD placement, during the clinic visit immediately after the first postinsertion menstrual period. According to the WHO Medical Eligibility Criteria for Contraceptive Use, PID is a condition that precludes the use of an IUD (risk category 4), but a past occurrence of PID is a condition for which the advantages of using intrauterine contraception generally outweigh the theoretical or proven risks (risk category 2).
• A four-year study found that the failure and expulsion rates for IUDs were lower for nulliparous women than for parous women. Another study that evaluated three types of IUDs in nulliparous women also found low failure and expulsion rates. According to the WHO Medical Eligibility Criteria for Contraceptive Use, nulliparity is a condition for which the advantages of using intrauterine contraception generally outweigh the theoretical or proven risks (risk category 2).

• A case-control study found that tubal infertility in nulliparous women was not linked to a history of IUD use but was significantly associated with the presence of antibodies to *Chlamydia*. WHO reviewed the available evidence and concluded that most of the data concerning the return to fertility after IUD use are reassuring.

References:


Education Tools and Reminder Devices

Since contraceptive efficacy depends on patient compliance, patients should be counseled on the importance of proper use. Printed materials, written at an appropriate reading level, should be provided to all patients at the time they are given the contraceptive or its prescription.

Women who use cyclic methods—oral contraceptives, pills, the patch, or injectable contraceptives—may benefit by setting a daily reminder on their cell phone, computer, or personal digital assistant. Electronic reminder devices are also available for purchase. The NuvaRing Vaginal Ring®, which is manufactured by Organon, offers downloadable software for computer users that can help remind them to change the ring. The same website also offers a timer that women can carry with them.

Some online pharmacies and pharmaceutical companies offer free e-mail reminder programs.

Women who use an injectable contraceptive should schedule their 12- to 14-week return visit at the end of their appointment in order to ensure continued protection.

Reference:
NuvaRing® Vaginal Ring NuvaTimer. Available at:
Contraceptive Methods: Benign Side Effects

Benign side effects can significantly influence a patient’s preference for one contraceptive method over another. Her ability to tolerate the physical effects, social influences, the opinion of her partner, or her own cultural beliefs can determine how effective she will be at using her method of choice.

For example, the documented cumulative weight gains experienced with injectable contraceptives may be unacceptable to women who struggle to maintain their weight. Excessive bleeding, a characteristic of the copper intrauterine device, can be considered by women to be unacceptable, as can be the erratic bleeding experienced when initiating or switching hormonal methods. Jewish Orthodox women will find these methods and the excessive bleeding associated with them unacceptable, because they must verify that there has been no recurrence of bleeding for the 7 days following the cessation of menstruation before they can resume sexual relations with their partner. As for other women, not being able to anticipate bleeding can interfere with their daily activities.

Nausea, bloating, and breast tenderness—characteristic of some hormonal contraceptive methods—can also be debilitating for some women.

Women who suffer from migraines will desire a method that does not exacerbate these types of headaches.
Noncontraceptive Benefits of Contraceptive Methods

Although hormonal contraceptive methods have side effects, these methods can also provide numerous benefits for cycle-related conditions, such as irregular menstruation, dysmenorrhea, or menorrhagia. Low-dose oral contraceptives also have demonstrated benefits for controlling mild to moderate acne, specifically for inflammatory lesions. Large, population-based studies indicate that oral contraceptive use is associated with a decreased risk of cervical, ovarian, and endometrial cancer. Although the noncontraceptive health benefits of the contraceptive patch and the vaginal ring are expected to be similar to that of the combination oral contraceptives, these effects are not as well characterized.

Injectable contraceptives can reduce or entirely eliminate menstrual bleeding, which may be viewed as a benefit by some women. This method of contraception is also associated with a decreased risk of endometrial cancer.

IUDs are associated with a decreased risk of endometrial cancer. The levonorgestrel-releasing intrauterine system (LNG-IUS) results in a reduction or absence of menstrual bleeding in many women. In fact, it has been used as a treatment for heavy menstrual bleeding.

Barrier methods are hypothesized to protect the cervix against a sexually transmitted infection. In a case-control study, women with cervical intraepithelial neoplasia (a precancerous sign of cervical cancer) were half as likely to have ever used a barrier method when compared with controls.

References:


Including the Partner in Contraceptive Counseling Improves Method Continuation Rates

Several studies have shown that men play an important role in supporting a couple’s reproductive health needs. A partner’s support has been shown to influence the effective use of a contraceptive method, impact the degree of a couple's satisfaction with a chosen method, and contribute to the better use of female methods when it is chosen over a male method. To illustrate this effect, data from a study by Terefe and Larson show that the contraceptive continuation rate after one year doubled among users who involved their partner in the counseling process.

References:
Sexuality Affects Contraceptive Choice

This table provides a comparison of contraceptive methods with regard to their relationship with a sex act and the need for partner support. The last column illustrates the need for additional protection that may be required to protect a woman from sexually transmitted infections.

Reference:

Counseling for Behavior Change: Steps to Follow

Clinicians know that even patients with the best intentions can fail to accomplish their goals. A model for behavior change, which has been successfully used for smoking cessation, relies on steps that follow a continuum toward the desired behavior. Psychologists generally agree that the continuum begins with an understanding of the facts that relate to the desired behavior.
Demonstrations of how to use a contraceptive method, and other forms of patient education, are appropriate means of improving a woman’s knowledge of contraceptives.

Comprehending the consequences of one’s behavior in light of new knowledge is the second stage of the continuum. To ensure that patients have reached this step in their understanding of the purposes and uses of contraceptives, have them answer such questions as: How do you envision your life in 3 to 5 years? How will having a baby now affect your personal goals?

Making a choice to use a contraceptive method has benefits and potential negative consequences for the patient, including side effects, loss of a partner, or even loss of self-esteem. When a patient chooses a contraceptive method, the clinician should be certain that the patient has verbalized these consequences and that the clinician has worked with the patient to overcome her fear of them. In doing so, the patient begins to build the skills (i.e. capacity) needed to succeed. Role playing at this stage will help build a patient’s skills to overcome barriers that others may impose upon her desire to change.

Along the continuum, the patient will try to achieve consistent behavior many times. Viewing all attempts as successes will improve self-efficacy and the patient’s ability to succeed. Self-efficacy is the ability of the individual to see herself as being able to make a change in behavior. A clinician’s reinforcement of the smallest accomplishments can be meaningful to the patient, as does taking the time to answer questions and alleviate concerns.

Reference:

### Principles of Effective Counseling

- Listen actively
- Assume nothing
  - Objective listening offers a common ground
  - Your patient may have more ways to solve her problems than you will
- Believe that your patient knows what she wants
- Respect your patient’s right to privacy

reproductive health and can be used to facilitate a productive conversation with patients regarding contraceptive choice:
Active listening is always helpful; some patients are merely seeking to be heard and understood. Health-care professionals should assume nothing and avoid making stereotypical judgments. A patient’s right to privacy should be respected and acknowledged.

It may be helpful to remind the patient that all conversations are confidential and that giving and receiving accurate, detailed information is the only way to provide the highest level of health care.

Reference:

Components of Informed Choice

- Inform the patient about complete range of options
- Allow the patient to choose freely
- Give the patient full disclosure about her choice
- Ask the patient to rephrase the information in her own words

Components of Informed Choice
Although some contraceptive methods (i.e., contraceptive implants; intrauterine devices) require informed consent before insertion, the principles of informed choice and full disclosure about that choice should be used in all contraceptive counseling.

Informed choice has three foundations. Ethically, people have a right to complete information about products or procedures that can affect their health and a right to decide what is done to their bodies. Pragmatically, patients are more likely to correctly and consistently use their contraceptive of choice when they choose it freely and understand it fully. Legally, the clinician must provide adequate information to help patients reach a reasonable and informed decision about medications, procedures, and devices, including contraceptive methods. To ensure that a patient comprehends the information provided to her, have her rephrase the information in her own words.

The ability to give consent may be compromised in some patients, such as the very young, the mentally ill, or the mentally disabled. Consultation with another health-care professional may be necessary in these cases.

Reference:
Contraceptive Counseling: The Patient Interview
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Summary

- Each visit with a female patient should include a discussion of her contraception needs.
- General counseling and education principles can be applied when discussing contraception.
- The counseling process is ongoing:
  - Assessment of patient needs.
  - Education on risks and benefits of methods.
  - Education on proper use.
  - Education on what to expect from method.