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# Motivational interviewing to improve postabortion contraceptive uptake by young women: development and feasibility of a counseling intervention ☆,☆☆

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## Abstract

**Objective:** The objective was to develop and test a postabortal contraception counseling intervention using motivational interviewing (MI) and to determine the feasibility, impact and patient acceptability of the intervention when integrated into an urban academic abortion clinic.
**Study design:** A single-session postabortal contraception counseling intervention for young women aged 15–24 years incorporating principles, skills and style of MI was developed. Medical and social work professionals were trained to deliver the intervention, their competency was assessed, and the intervention was integrated into the clinical setting. Feasibility was determined by assessing ability to approach and recruit participants, ability to complete the full intervention without interruption and participant satisfaction with the counseling.
**Results:** We approached 90% of eligible patients and 71% agreed to participate ($n$=20). All participants received the full counseling intervention. The median duration of the intervention was 29 min. Immediately after the intervention and at the 1-month follow-up contact, 95% and 77% of participants reported that the session was helpful, respectively.
**Conclusions:** MI counseling can be tailored to the abortion setting. It is feasible to train professionals to use MI principles, skills and style and to implement an MI-based contraception counseling intervention in an urban academic abortion clinic. The sessions are acceptable to participants.
**Implications:** The use of motivational interviewing in contraception counseling may be an appropriate and effective strategy for increasing use of contraception after abortion. This study demonstrates that this patient-centered, directive and collaborative approach can be developed into a counseling intervention that can be integrated into an abortion clinic.


*Keywords:* Motivational interviewing; Contraception; Abortion; Adolescents; Contraception counseling; Counseling intervention

## 1. Introduction

In the United States, 21%–27% of women who have an abortion experience a repeat pregnancy within 12 months, and repeat abortion incidence is 11%–15% within 1–3 years [1,2]. Although many women presenting for abortion have decided on a method of contraception and do not consider themselves in need of counseling [3], two thirds of women who present for abortion desire a contraceptive method at their visit and believe that it is an appropriate time to discuss contraception [4]. For those women who do desire counseling or want to leave the abortion visit with a contraceptive method, patient-centered and effective counseling interventions are needed.

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Relatively few trials have examined contraception counseling at the time of abortion, and most have not shown an increase in contraceptive uptake [5,6]. However, these trials may have been limited by their lack of attention to a theoretical basis for the counseling intervention. Given the challenge of adopting new behaviors, behavioral theory-based, tailored approaches to contraception counseling may be important additions to educational interventions.

Motivational interviewing (MI) is an evidence-based counseling approach defined as "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" [7]. MI relies on a therapeutic and collaborative relationship between counselor and patient, respect for autonomy, deep empathic understanding and exploration of ambivalence without prejudice or coercion. While MI is not a theory, the MI counseling style was developed based on the tenets of established behavioral theories such as Social Cognitive Theory [8], Discrepancy Theory [9,10], Decision Theory [11], Self-Perception Theory [12] and Self-Determination Theory [13,14]. The four key principles of MI include: (a) express empathy, (b) develop discrepancy if it exists, (c) roll with resistance and (d) support self-efficacy. These principles foster a collaborative and noncoercive approach that is well suited to the preference-sensitive nature of contraceptive choice. The expression of empathy is key to the relational component of MI, in which the counselor strives to establish an empathic understanding of the patient's experience through the skillful use of reflective listening and nonjudgmental acceptance of the patient's position, including her ambivalence. It is through the nonjudgmental exploration of this ambivalence that the patient is able to examine her own arguments for change, change that can be further motivated if there is discrepancy between present behavior and personal goals and values. In this process, the patient is seen as the primary resource in identifying any existing discrepancy, as well as the primary resource in finding answers and solutions when needed. The counselor avoids arguing for change and recognizes that resistance, as a normal part of ambivalence, is only strengthened when opposed. Additionally, resistance may also be an expression that no change in behavior is required. Support for the patient's self-efficacy and her autonomy enhances the person's belief in the possibility of change, which is an important motivator. At its core, MI recognizes that people are "the undisputed experts on themselves" [15].

MI has been successfully applied to address an array of health-related behaviors, including improvement in weight loss, blood pressure control and substance use, and for contraception use [16–18]. Additionally, MI lends itself to single-session interventions, which may be more feasible than longer or multivisit interventions in health care settings [16,19]. However, MI has not been studied for contraception counseling at the time of abortion. In the specific context of postabortion contraception counseling, MI seeks to establish a supportive and empathic relationship in which to elicit the patient's life goals and values, to identify contraception options that are consistent with those goals and values, and to explore and resolve any ambivalence among those choices.

This paper describes the development of, counselor training for and feasibility testing of an MI-based contraception counseling intervention to help young women utilize effective contraception after abortion.

## 2. Materials and methods

We developed a seven-step, postabortal contraception counseling intervention incorporating MI principles, skills and spirit. We paid particular attention to adapting the intervention to the physical, social and therapeutic environment of the clinical setting and attending to issues of limited education and health literacy among the patient population (Fig. 1). The seven steps to be performed during the counseling intervention were outlined in a two-page guide provided to each counselor. The contraception education component of the intervention used a pictorial guide to contraception adapted from the US Agency for International Development (USAID) and World Health Organization (WHO) [20], in which contraceptive methods are organized in tiers based on their level of effectiveness. Counselors emphasized the effectiveness of the top two tiers, noting that second-tier methods (e.g., combined hormonal contraceptives) require regular action to maintain effectiveness. Although order of initial discussion of methods was organized by effectiveness, participant preferences for contraceptive characteristics other than effectiveness were acknowledged and incorporated into the intervention. While the "directive" nature of MI is reflected in that the intervention was designed to encourage uptake of highly effective contraception after the abortion procedure, participant preference, even if that preference was for nonuse of contraception or avoidance of perceived contraceptive inconvenience or side effects, was valued and respected.

Four health care professionals completed training to deliver the single-session counseling intervention; three were evaluated for competency. The fourth counselor left the institution before skills were assessed. Due to cost constraints, it was not feasible to either train more than four counselors or train a new counselor after the fourth counselor left the institution. Of those evaluated, two were physicians (A.W. and E.W.) and one was a social work student (A.T.). None had prior experience using MI. The training program was designed and implemented by co-investigator M.Q. Initial training included two 3-h sessions of instruction on the theory and spirit of MI, evidence for its efficacy, videotaped and live demonstrations of MI counseling, and role-play with feedback to practice MI skills, including (a) reflective listening; (b) avoidance of confrontation; and (c) collaborative, open discussion of the pros and cons of contraceptive methods [7].

The training then included 5 h of encounter and feedback utilizing professional standardized patients with the University of Chicago Simulation Center. We videotaped MI-based