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Analysis of Contraceptive Self-Efficacy in Clients Requesting Emergency Contraception

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Analysis of Contraceptive Self-Efficacy in Clients Requesting Emergency Contraception

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Abstract

Objective: To analyze the level of contraceptive self-efficacy in women requesting emergency contraception (EC), and to suggest appropriate assessments and interventions to promote optimal contraception.

Design: A quantitative survey administered to 55 clients requesting emergency contraception over a 3-month time span.

Setting: One Planned Parenthood community clinic in San Jose, California.

Patients/Participants: Women who were 18 years or older, English speaking, and requesting emergency contraception were asked to complete the survey by clinic staff.

Interventions: No interventions were performed in the study. Implications for practice are suggested by the interpretation of the survey data.

Main Outcome Measure(s): Participants scored high on the contraceptive self-efficacy (CSE) scale in comparison with the normative samples.

Results: Clients in this setting requesting emergency contraception have a high level of contraceptive self-efficacy.

Conclusion: Contraceptive counseling with clients requesting emergency contraception should acknowledge their level of self-efficacy and allow for mutual decision-making.

Keywords: contraceptive self-efficacy (CSE), emergency contraception (EC), morning after pill, family planning,

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Callouts

Method failures are always possible, but are usually preventable. (Callout should appear with background and significance)

The population who is utilizing EC is an educated group of women. They adhere to the recommended time constraints of EC, and have had a great amount of experience with continuous birth control methods, yet they are not currently utilizing a method. (Callout should appear with discussion)

Self-efficacy should be reinforced during interactions with these clients, but does not necessarily require interventions aimed at increasing self-efficacy. (Callout should appear with practice implications)

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Analysis of Contraceptive Self-Efficacy in Clients Requesting Emergency Contraception

Background and Significance

Contraception is always a "hot topic". It becomes even more so when it involves adolescents. It is not uncommon to have a Monday morning rush, in the family planning clinic, with women requesting post-coital contraception or emergency contraception (EC), after the clinic has been closed over the weekend. Many of these women are adolescents. With the wide availability and near 100% efficacy of today's birth control methods, it is curious that EC is requested in the quantity in which it is dispersed. In the literature related to EC many studies discuss the effectiveness and availability of the method, but little else. There is minimal published information regarding the characteristics of women utilizing EC.

EC is suggested for use in the instance of a failure of a (barrier) contraceptive method, or if no contraception is utilized at the time of intercourse, when pregnancy is not desired. Anecdotal clinical observations show that it is being used by sexually active women who are not using a contraceptive method for unclear reasons, but that do not desire to become pregnant.

Optimal contraception would be abstinence, or the utilization of a reliable continuous birth control method. Promotion of either of these methods may be

appropriate for some and not for others. Accurate individual assessment is needed to allow for appropriate intervention.

Many proponents of EC note in their studies that its 75-89% effectiveness can greatly decrease unwanted pregnancies and elective abortions. (Coeytaux & Pillsbury 2001; Gold, Sucato, Conard, & Hillard 2004; Grossman 2001; Hayes Hutchings & Hayes 2000; Roye & Johnsen, 2002). The need for increased access and utilization of EC is mentioned in the literature, but little is noted about how to utilize client interaction to promote continual contraception.

Emergency contraception is a form of post-coital contraception that helps to prevent pregnancy from occurring. The woman takes the prescribed amount of oral hormones within the first 120 hours after unprotected intercourse when pregnancy is not desired. Emergency contraception is not to be confused with RU-486 or the abortion pill. If the woman has already become pregnant, emergency contraception will not harm or terminate the pregnancy; it is only used to prevent pregnancy from occurring. The methods of action are: inhibiting ovulation, disrupting follicular development and/or interfering with the maturation of the corpus luteum (Gold et al. 2004).

Occasionally there is confusion about EC. It is also known as the morning after pill, or the Yuzpe regimen, Plan B or Preven (Gold et al. 2004). It was originally a combination of high dose progesterone and estrogen in the form of multiple pills of a 28-day pack of oral contraceptives and then repeating the dose

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12 hours later. Progesterone only formulations, such as Plan B, balance high efficacy and safety, with minimal side effects. Current recommendations from the Society of Adolescent Medicine are to take the two prescribed tablets at once, rather then waiting 12 hours before the second dose (Gold et al. 2004).

This article discusses the level of contraceptive self-efficacy (CSE) in women requesting EC. CSE is defined by Levinson, Wan, &Beamer (1998) as the strength of conviction that a sexually active individual should and can control sexual and contraceptive situations to achieve a contraceptively protected priority. Emergency contraception, just as it is titled, is to be used in an "emergency". The insight gained by the interpretation of the results of this study suggests interventions related to the client's perceived ability to control sexual and contraceptive situations and their utilization of EC.

When a client requests EC it is assumed that they either experienced a contraceptive method failure, or that they weren't using a contraceptive method. Method failures are always possible, but are usually preventable. Continuous contraceptive methods are generally safe, efficacious and easily accessible. This study analyzes the level of contraceptive self-efficacy (CSE) in clients requesting emergency contraception in order to develop a better understanding of the challenges perceived by these clients. The study also suggests appropriate assessments and interventions based on data reflecting self-efficacy.

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Literature Review

Levinson (1986) initially developed the CSE tool to better understand the characteristics of the contraceptively self-efficacious teenager. She used it with a group of 258 female clients age 20 or younger in a family planning clinic in Sunnyvale California. Effective contraception was reported as 23% for this sample. In the factor analysis of the scale four factors emerged. These factors were (a) conscious acceptance of sexual activity by planning for it, (b) assumption of responsibility for the direction of sexual activity and for using contraception, (c) assertiveness in preventing sexual intercourse in an involved situation and (d) strong feelings of sexual arousal (Levinson 1986).

Levinson (1995b) utilized the research from the previous article and results from a survey of 263 women age 20 or younger in a Chicago, Illinois family planning clinic. These results were used to further analyze the CSE construct in relation to reproductive and contraceptive knowledge (RCK) and contraceptive behavior. In addition to the CSE tool, the respondents were asked to provide information on contraceptive use, demographics, sexual experience, an index of reproductive and contraceptive knowledge (IRCK), and psychosocial factors. Results of this study found that the CSE statements are behaviorally specific to the kinds of cognitive, emotional, and physical situations and demands that teenage women experience over time in being sexually active and in trying to use contraceptives. The data analysis of this study showed that CSE is related to

contraceptive behavior, but did not show a direct relation between knowledge and contraceptive practices. Effective contraception was reported as 30% for this sample (Levinson 1995b).

The Sunnyvale and Chicago samples were compared with results of the survey administered in two other settings. In Montreal by Bilodeau, Forget and Tetreault (1994), the tool was translated into French and used with 231 9th and 10th grade males and females in the classroom setting. Effective contraceptive use was reported as 62% for the sexually active portion of this sample.

The tool was also used in the classroom setting in two separate studies and results were combined into the American sample of 148 undergraduate college males and females. Heinrich's (1993) study at a Northeastern university, and Wright's (1992) study of black college students combined to create this college sample for comparison with Sunnyvale, Chicago and Montreal. In both of these College samples, Contraceptive Self-Efficacy scores were significantly related to contraception and were the most important predictors of contraceptive use. Effective contraception was reported as 21% for this sample.

In the data provided as normalization for possible clinical use of the items the Chicago sample was omitted because of its variance in the response metric. The Chicago sample used a 3-point scale whereas the other samples used a 5-point scale. This comparison yielded recommendations for the further use of the scale as a total item set with a 5-point scale for comparisons with the provided

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sample norms. A recommendation to extend CSE analyses to older adolescents was also identified, as well as its use with a variety of young women's contraceptive behaviors (Levinson Wan &Beamer 1998).

Conceptual Framework

Bandura's (1986) research on self-efficacy serves as a theoretical framework for this study. The motivational factors of the individual utilizing EC are in question. The results of the survey uncover areas for further research and implications for assessment and intervention related to the perceived self-efficacy of women requesting EC. In Bandura's (1986) discussion of the self-efficacy mechanism in human agency, the need for accurate appraisal of one's own capabilities in order to facilitate successful functioning is highlighted. It is noted that large misjudgments of personal efficacy in either direction have consequences. Individuals who overestimate their capabilities can undertake activities that are unmanageable; likewise, people tend to avoid tasks that are perceived as exceeding their capabilities. It is noted by Bandura that "people who regard themselves as highly efficacious act, think and feel differently from those who perceive themselves as inefficacious. They produce their own future, rather than simply foretell it." (p. 395)

In order to facilitate optimal contraception it is important to not only identify the level of self-efficacy in clients but also to instigate a call to action. Bandura (1986) discusses this relationship between self-efficacy judgment and

action. Individuals must not only perceive themselves as efficacious, but they must also embody the necessary subskills for the exercise of personal agency. Even if an individual has the skills and a strong sense of self-efficacy they must also perceive the task as important, and see an intrinsic or extrinsic incentive for their performance.

Methodology

Design

This is a quantitative descriptive study to measure CSE in a convenience sample of 55 clients requesting EC at one Planned Parenthood location. In addition to the CSE survey, questions requesting background information from the patients were asked.

Approval to carry out the study was obtained by San Jose State's Institutional Review Board (IRB) as well as Planned Parenthood's Director of Clinical Trials. Authorization to use the CSE tool was obtained from its author.

The Planned Parenthood clinic staff were informed of the study, and asked to disperse the surveys to clients. The surveys were collected weekly, and the results analyzed after a 55 completed surveys were obtained.

Participants were asked to read the informed consent, and completion of the survey implied informed consent. Participation was anonymous and not associated with the services rendered by Planned Parenthood. The participants

were asked to retain the information and consent form and return the completed survey with other paperwork required for the visit.

Sample

All women who entered a Planned Parenthood clinic in San Jose and requested EC were asked to complete the survey. There were no demographic criteria for participation in the study with the exception of gender and age. Only women are able to obtain EC, and only women were asked to complete the survey. Clients must have been at least 18 years of age in order to consent to participate in the study.

The survey took approximately 10 minutes to complete. The average wait time for a clinic visit was 20-30 minutes, so there were no additional time constraints for the clients asked to participate in the study. There was no compensation awarded to the subjects for participating in the study. There were no direct risks of completing the study with the exception of any unforeseen mental anguish that may be caused by the sensitive subject matter of the questions related to sexuality and contraception.

Instruments

Levinson (1998) developed a CSE scale that has been utilized in the analysis of contraceptive behavior, specifically motivational barriers to contraceptive use among sexually active teenagers. It measures strength of conviction that one can control sexual and contraceptive situations in order to

prevent pregnancy. The CSE tool was designed as a diagnostic tool for clinicians and educators to aid in the design and assessment of interventions; it may also be used as a research instrument for further work in reproductive health (Levinson, 1995a).

The 18-question Likert scale assesses CSE using situational items which respondents rate on a scale from 1 (not at all true of me) to 5 (completely true of me). Participants are asked to rate their congruence with behaviors in these sexual and contraceptive situational vignettes (See Appendix). Higher scores represent higher CSE. Item numbers 2, 5, 6, 8, 9, 11, 12, 14 and 15 are reverse scored with a lower score representing higher CSE. Item 8, related to "discourse of desire" was consistently predictive of contraceptive behavior across three of the four samples in which it was analyzed (Levinson 1995a).

Face and content validity of the CSE tool was established by factor analytic techniques that examined the scale in relation to contraceptive behavior (Levinson 1986). A reliability coefficient of .73 was determined by using Cronbach's alpha across investigations (Levinson 1995a).

Data Analysis

The 18 item, CSE survey and additional demographic questions yielded a variety of descriptive data regarding the type of client who is utilizing EC. The CSE Likert scale responses were averaged and compared to results from previous studies to interpret the level of contraceptive self-efficacy in this population.

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Results

The sample consisted of primarily Caucasian (38.2%) and Hispanic (32.7%) women between the ages of 18 to 29 years (mean = 21 years). Religious affiliation was reported by 78.2% of the clients. The reported religious affiliations were overwhelmingly Catholic/Christian. Over two thirds (78.2%) of the women reported current college attendance. See Table 1.

Over one fifth of the clients (21.8%) reported no current birth control method, and almost half (49.1%) were using condoms only. The majority (69%) of these women had previously used at least one birth control method other than condoms. Common birth control methods included pills, patch, and Depo Provera. Almost one fourth (23.6%) of women reported using no birth control method for at least one year. Over half (50.9%) of the respondents reported side effects as a barrier to contraceptive use. See Table 2.

On average the clients had used EC one time in the last year, with 30.9% of women having used it 2 or more times. Over half (50.1%) of women were timely in getting to the clinic within the first 24 hours after unprotected intercourse. Very few (5.4%) women arrived at the clinic after 72 hours had passed. See Table 3.

Over half (58.2%) of the respondents were having intercourse at least once a week, or >4 times per month. Less than one fourth (21.8%) of the women had

ever been pregnant. Of the pregnancies that had occurred in these women, two thirds (66.6%) ended in abortion. See Table 4

The analysis of the data showed that clients requesting EC in this study scored higher on the CSE scale than the Sunnyvale sample on all items with the exception of item 8. In comparison with the Montreal, and College samples this sample scored similarly with the values reported as normative data by Levinson, Wan and Beamer (1998). A graphical depiction of the mean scores for these four groups is presented in Figure 1.

Discussion

Figure 1 shows a comparison of mean CSE item scores between the San Jose sample discussed in this research, and the Sunnyvale, Montreal, and college samples presented in Levinson Wan &Beamer (1998) as normative data. The San Jose sample showed the highest CSE scores in two factors: assumption of responsibility for sexual activity and contraception, and assertiveness in preventing sexual intercourse. This sample also had the highest CSE scores in 2 of the 5 items related to strong feelings of sexual arousal. For of the remaining items related to this factor, the San Jose group scored close to the highest score. However, for Item 8 the San Jose group scored the lowest. Item 8 related to "discourse of desire" was found to be consistently predictive of contraceptive behavior across three of the four samples in which it was previously analyzed. A low score would suggest that the San Jose sample did not exercise control over

contraceptive behavior. The San Jose group did not score as well on items related to the factor of conscious acceptance of sexual activity. See Table 5

It is insightful that the San Jose sample scored so low in CSE on Item 8. The item reads: There are times when I'd be so involved sexually or emotionally that I could have intercourse even if I weren't protected (using a form of birth control). This is exactly the phenomenon in which EC is indicated for use. The survey results are congruent with anecdotal observations. This observation indicates that these women are in need of interventions that increase their acceptance of sexual activity and reproductive consequences.

The population who is utilizing EC is an educated group of women. They adhere to the recommended time constraints of EC, and have had a great amount of experience with continuous birth control methods, yet they are not currently utilizing a method. Their consistent high self-efficacy scores on the CSE scale related to sexual and contraceptive responsibility and assertiveness in preventing sexual intercourse show much promise. Their lower CSE scores related to conscious acceptance of sexual activity identify possible areas for intervention.

The most common barrier to continual contraception reported was side effects. Specific side effects were not stated, but over half (50.9%) of women indicated that side effects were a barrier to contraceptive use. It is possible that these women have analyzed the risks and benefits of continual contraception and that they do not perceive it to be to their benefit to use a continuous contraceptive

method. Given the low incidence of pregnancy, and the high percentage of terminations in the presence of pregnancy, it may also be that this group of women view abortion as a viable solution to an unplanned pregnancy. This is a bit surprising with the reported religious affiliations of these clients. Half of the clients who reported religious affiliations indicated Catholicism as their religion. This may have bearing on their declination of contraceptives, but does not explain the high proportion of abortions.

The conceptual framework of this study is relevant to the baseline level of self-efficacy of the clients in question. Their level of self-efficacy suggests that particular interventions related to recommendations for the enhancement of self-efficacy in the client may be needed. It is integral that individuals have confidence in their ability to contracept. The use of interventions based in self-efficacy ensures that knowledge will be transmitted and that the client will gain the confidence needed to integrate the feelings of self-efficacy and abilities to control sexual and contraceptive situations. Albert Bandura (1986) the father of self-efficacy says, "Competent functioning requires both skills and self-beliefs of efficacy to use them effectively" (p. 391).

Limitations

Young women become sexually active at various ages. Their sense of reproductive responsibility also develops at various ages. This study was limited

to clients who were at least 18 years old. The results of this study are specific to this population, and may not be generalized to clients less than 18 years of age.

A significant number of Planned Parenthood clients are Spanish speaking. The CSE tool was not translated into Spanish for this study. The results will be generalizable only to English speaking women requesting EC. Because of the possible cultural differences in the Hispanic population, study results from an English-speaking population will provide guidelines for further studies of culturally diverse populations.

The descriptive data analysis from this study revealed many interesting phenomena. No correlations or tests of significance were performed.

Research Implications

The results of this study point to further research needed in assessing the perceived barriers to contraception in clients utilizing EC. Given their high level of CSE and perceived ability to control sexual situations it seems as though women would be eager consumers of knowledge regarding contraceptive options. Further studies on this population with regard to specific perceived side effects of continual contraception would also be helpful to providers. Analysis of possible reasons for the lower CSE scores related to conscious acceptance of sexual activity may also provide insight.

Practice Implications

Women who are utilizing EC require special attention. Interactions with these women should assess the clients perceived barriers to contraception and mutual brainstorming of possible methods that would be appropriate given the client's individual needs. These women are at risk for pregnancy given their frequency of intercourse and lack of contraceptive use. It is important to acknowledge the client's concerns and identify contraceptives that are appropriate for the specific client situation. Given the fact that these clients have utilized multiple contraceptive methods in the past, it may be possible to have a more in depth discussion of particular methods in comparison with one another. Self-efficacy should be reinforced during interactions with these clients, but does not necessarily require interventions aimed at increasing self-efficacy. Providers should assess clients' conscious acceptance of sexual activity in order to promote self-efficacy in this area that showed lower scores in the factor analysis. An appeal to the previous experiences of the client will also aid in the adoption of continual contraception.

Conclusion

There is minimal published information regarding the characteristics of women utilizing EC. Analysis of the mental characteristics of the client utilizing EC is essential to the development of evidence-based practice. EC is suggested for use to prevent pregnancy, in the instance of a failure of a (barrier) contraceptive method, or if no contraception is utilized at the time of intercourse,

when pregnancy is not desired. The analysis of the results from the contraceptive self-efficacy scale with clients requesting EC shows that these women have a high level of perceived ability to control sexual and contraceptive situations and raises the issue about why they are not using continual contraception. Findings from this study may help to guide assessments and interventions of these clients to promote optimal contraception.

Two major areas for assessment and intervention are (a) client reported side effects of continuous contraception and (b) increasing the client's conscious acceptance of sexual activity. Methods of assessment and intervention with the client requesting emergency contraception may help to promote optimal contraceptive utilization and ultimately the prevention of unwanted pregnancies, and appropriate timing of desired pregnancies.

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401 Table 1.

402 Demographic Variables

Characteristic	Range	Mean	SD
Age (years)	18-29	21	2.71
Age at first intercourse	13-22	17	1.91
Ethnicity	n	%	
Caucasian	21	38.2	
Hispanic	18	32.7	
Asian	8	14.5	
Filipino	4	7.3	
African American	2	3.6	
Religion	n	%	
Catholic	21	38.2	
Christian	21	38.2	
Christian Science	1	1.8	
Education	n	%	
College	43	78.2	
High School	2	3.6	

403

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403 Table 2.

404 Contraceptive Practices

Current Birth Control Method	n	%
None	12	21.8
Condoms Only	27	49.1
Condoms and Pills	9	16.4
Pills	5	9.1
Depo	1	1.8
Ring	1	1.8
Past Birth Control Method		
None	1	1.8
Condoms only	16	29.1
Pills only	2	3.6
Depo only	3	5.5
Condoms/Pills	20	36.4
Pills/Patch	1	1.8
Condoms/Pills/Patch	6	10.9
Condoms/Pills/Depo	2	3.6
Condoms/Pills/Patch/Depo	2	3.6
Condoms/Pills/Patch/Ring	1	1.8
IUD	1	1.8
How long since last on Birth Control Method		
Never	1	1.8
Currently on BCM	22	40.0
0-6 months	17	30.9
6-12 months	1	1.8
>1 year	5	9.1
>2 years	8	14.5
Barriers to Birth Control		
Side Effects	28	50.9
Cost	8	14.5
Availability	7	12.7
Parents	2	3.6
Minimal Sexual Activity	2	3.6

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405 Table 3.

406 EC Practices

Frequency of EC use in the last year	n	%
0	22	40.0
1	16	29.1
2	12	21.8
3	4	7.3
4	1	1.8
Elapsed time from unprotected intercourse		
<24	28	50.1
24-48	16	29.1
48-72	7	12.7
98-120	1	1.8
>120	2	3.6

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Table 4.

Coital and Pregnancy Practices

Monthly frequency of sexual intercourse	n	%
0-1	7	12.7
2-3	16	29.1
4-8	14	25.5
>8	18	32.7
Pregnancy History		
Never Pregnant	43	78.2
Ever Pregnant	12	21.8
Ever Baby	4	7.1
Ever Abortion	10	18.2
Ever Miscarriage	1	1.8

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410 Table 5

411 CSE Factor Analysis

Factor	Item #	San Jose	Sunnyvale	Montreal	College
Conscious acceptance of sexual activity	2_a	2.24	3.99	1.86	2.02
	5_a	2.09	3.71	1.95	2.07
	6_a	2.04	4.23	1.93	2.10
	12_a	2.31	3.41	1.66	2.37
	14_a	1.65	4.18	1.45	1.55
	15_a	1.40	4.42	1.34	1.32
Assumption of responsibility for sexual activity and contraception	1	4.27	3.57	3.45	3.69
	13a	4.67	4.17	3.92	4.41
	13b	4.02	3.74	4.02	3.97
	13c	4.67	4.40	4.20	3.49
Assertiveness in preventing sexual intercourse	4	4.47	3.98	3.57	4.00
	7	4.16	3.78	3.16	3.99
	13d	4.22	3.55	2.91	4.01
Strong feelings of sexual arousal	3	4.42	4.39	4.31	4.47
	8_{ab}	3.11	2.88	2.10	2.18
	9_a	1.40	4.57	1.74	1.64
	10	3.31	2.98	2.90	2.80
	11_a	1.67	4.42	1.44	1.70

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413 *Note*. Highlighted scores indicate greatest level of self-efficacy

414 [a]Indicates reverse scored items.

415 [b]Indicates item with consistent predictability of contraceptive behavior

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Figure 1. CSE Mean Score Comparison

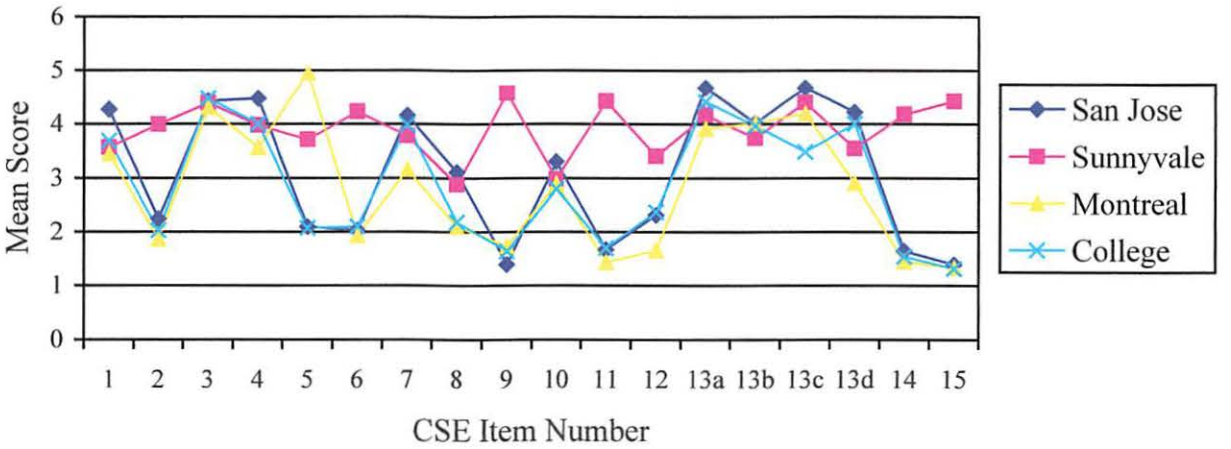

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Figure Caption

Figure 1. Item numbers 2, 5, 6, 8, 9, 11, 12, 14, 15 are reverse scored with lower values indicating higher CSE

Appendix

Perceived Sexual/Reproductive Control: Contraceptive Self-Efficacy Tool

The items following are a list of statements. Please rate each item on a 1 to 5 scale according to how true the statement is of you. Using the scale, circle one number for each question:

1 = Not at all true of me
2 = Slightly true of me
3 = Somewhat true of me
4 = Mostly true of me
5 = Completely true of me

1) **1 2 3 4 5** When I am with a boyfriend, I feel that I can always be responsible for what happens sexually with him.

2) **1 2 3 4 5** Even if a boyfriend can talk about sex, I can't tell a man how I really feel about sexual things.

3) **1 2 3 4 5** When I have sex, I can enjoy it as something that I really wanted to do.

4) **1 2 3 4 5** If my boyfriend and I are getting "turned on" sexually and I do not really want to have sexual intercourse (go all the way, get down), I can easily tell him "No" and mean it.

5) **1 2 3 4 5** If my boyfriend didn't talk about the sex that was happening between us, I couldn't either.

6) **1 2 3 4 5** When I think about what having sex means, I can't have sex so easily.

7) **1 2 3 4 5** If my boyfriend and I are getting "turned on" sexually and I don't really want to have sexual intercourse (go all of the way, get down), I can easily stop things so that we don't have intercourse.

8) **1 2 3 4 5** There are times when I'd be so involved sexually or emotionally that I could have intercourse even if I weren't protected (using a form of birth control)

9) **1 2 3 4 5** Sometimes I just go along with what my date wants to do sexually because I don't think that I can take the hassle of saying what I want.

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10) **1 2 3 4 5** If there were a man (boyfriend) to whom I was very attracted physically and emotionally, I could feel comfortable telling that I wanted to have sex with him.

11) **1 2 3 4 5** I couldn't continue to use a birth control method if I thought that my parents might find out.

12) **1 2 3 4 5** It would be hard for me to go the drugstore and ask for foam (Encare Ovals, a diaphragm, a pill prescription, ect,) without feeling embarrassed.

13) If my boyfriend and I were getting really heavy into sex and moving towards intercourse and I wasn't protected . . .

A) **1 2 3 4 5** I could easily ask him if he had protection (or tell him that I didn't).

B) **1 2 3 4 5** I could excuse myself to put in a diaphragm or foam (if I used them for birth control).

C) **1 2 3 4 5** I could tell him I was on the pill or had an IUD (if I used them for birth control).

D) **1 2 3 4 5** I could stop things before intercourse, if I couldn't bring up the subject of protection.

14) **1 2 3 4 5** There are times when I should talk to my boyfriend about using contraceptives, but I can't seem to do it in the situation.

15) **1 2 3 4 5** Sometimes I end up having sex with a boyfriend because I can't find a way to stop it.

Note: The CSE scale was previously published in "Contraceptive Self-Efficacy: A perspective on teenage girls' contraceptive behavior" by R. A. Levinson (1986). Journal of Sex Research, 22, 351.

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Age: _____ Race:_____Religion:_____

Occupation:_____Student: (circle one) High School College N/A

1) What Birth Control method are you currently using?
None Condoms Pills Patch Ring IUD Other _____
2) What Birth Control methods have you used in the past? (Circle all that apply)
None Condoms Pills Patch Ring IUD Other_____
3) How long has it been since you were using a method?
I am currently on a method 0-6 months 6-12 months >1 yr >2 yrs
4) How many times have you used EC (emergency contraception) in the past 12 months?
0 1 2 3 4 5 >5
5) How long has it been since your last unprotected intercourse?
<24 hrs 24-48 hrs 48-72 hrs 72-96 hrs 98-120 hrs >120 hrs
6) At what age did you first have sexual intercourse? _____
7) How often do you have sexual intercourse?
0-1 times/month 2-3 times/month 4-8times/month >8 times/month
8) What barriers do you feel keep you from using a birth control method?
Cost Side Effects Availability of method Other _____
9) Have you ever been pregnant? Yes No
Live Births_____ Abortions_____Miscarriages_____