ease and pregnancy. Yet their target group for directive counseling—poor, minority women—is the very profile of women most at risk for these other serious outcomes. If a woman prefers one method to provide dual coverage against pregnancy and disease, long-acting contraceptives do not serve her long-term interests. Many women wrongly perceive their contraceptive as providing "all around" protection, implying a dangerous lack of information at the counseling level. In fact, some hormonal methods may even raise the risk of certain sexually transmitted diseases. Finally, some women have valid complaints about irregular bleeding and other side effects.

In summary, we find that techniques designed to change women's minds about contraception, after they are fully informed, are not only ethically unsound but potentially harmful to women's health and welfare.

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**Directive Counseling Should Emphasize Disease Protection, Not Pregnancy Prevention**

Moskowitz and Jennings argue that directive counseling on long-acting contraception can be appropriate and that family planners should develop protocols to that effect. We disagree.

Directive counseling for long-acting contraception is a mistake. Virtually every woman described as a candidate for directive counseling is also at risk for sexually transmitted diseases (STDs). Directive counseling should be considered, but for condoms and other barrier methods, not for long-acting contraception.

We often hear from family planners that women at risk for two unwanted outcomes—pregnancy and STDs—will be better off if they use a long-acting method that effectively prevents pregnancy rather than trying to use a barrier method, failing, and giving birth. Again, we disagree. Women whose birth control fails have another chance to prevent giving birth, but women infected with herpes, condyloma, or HIV have no more chances for prevention.

Current value-neutral counseling that encourages women to choose their contraceptive first and then use condoms to prevent STDs is not working well enough. Far too many women at risk for STDs use nothing to prevent disease. Directive counseling to use long-acting methods will not help this situation. Adolescent mothers given Norplant after childbirth experienced the same high rate of STD infection (42% within 6 months) as did women using oral contraceptives.

What we need now is counseling that strongly encourages and even directs women to use the most protective method possible. Women who receive such counseling will be more likely to avoid disease and will have a decent chance at highly effective contraception as well. Both male and female condoms can be very effective birth control devices. Barriers that do not provide the total physical protection necessary to completely prevent HIV infection can provide significant protection against other STDs, thus reducing the increased vulnerability to HIV caused by certain STDs.

It is time for a shift in the counseling strategies used in family planning clinics. Directive counseling may be the right technique, but long-acting contraception is not the right message.

**References**


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**Moskowitz and Jennings Respond**

Gollub and Isaacs misread our piece, finding an attack on informed consent and women's rights despite our many explicit arguments that directive counseling can and should be based on those very principles and need not be inherently in opposition to them. For example, we write that counselors' involvement in directive counseling depends on their having already described the full "range of contraceptive options" to the client and that "counseling protocols should require that principles of informed consent be honored." It is hard to imagine how we could be more explicit. We do not embrace coercion; the final informed decision remains with the client.

Gollub and Isaacs' oversight reflects the fact that challenges to the model of nondirective counseling touch a raw nerve in the field. Nonetheless, we believe it is time for counselors to take seriously the model's limits. Respect for choice does not, under circumstances we limit and define, make it illegitimate for a counselor to (1) form an opinion that a long-acting method would probably work well for a particular client and (2) explain this opinion (and its basis) to the client with the aim and hope of convincing the client of its wisdom. We advocate making a space for recommendation and persuasion, which research already indicates can be welcomed and beneficial.

This directive counseling model obviously encompasses education in a sense that is broader than merely conveying technical information. However, not every client will have perfect insight, following a dispassionate discussion of the available methods, about which methods would best serve her interests. We also know full well that there is no "ideal" contraceptive, and that a counselor's opinion may prove wrong. Our point is that withholding professional recommendations out of a fear that to speak is to coerce will not only underestimate clients'