

increased intensity at the end of the first cycle but eventually were minimal. This is also reflected by the fact that 12/13 patients who completed the study have continued to take Yasmin subsequently. We were therefore unable to assess the changes in the metabolic profile and return of symptoms after completion of the trial.

Conclusions

Yasmin provides good cycle control and relief of acne without having a beneficial effect on hirsutism after 6 months' therapy. BMI and mean blood pressure were unchanged, although percentage body fat and fasting insulin concentrations increased. We are currently performing a prospective, randomised controlled trial of Yasmin vs Dianette and further randomised studies are required to compare the efficacy of Yasmin with other preparations for the treatment of PCOS.

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ORIGINAL ARTICLE

Pregnancy counselling clinic: a questionnaire survey of intimate partner abuse

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Abstract

Context Intimate partner abuse has a significant and detrimental impact on the mental and physical health of a woman. Physical abuse is often associated with sexual abuse.

Objective To examine the prevalence and nature of physical and sexual partner abuse experienced by women who request a termination of pregnancy (TOP).

Design Quantitative data collection using an anonymous, self-completed questionnaire.

Setting A pregnancy counselling clinic located within a large district general hospital in the north west of England.

Participants A sample of 312 women attending the clinic.

Results Three hundred and twelve questionnaires were returned (96.7% response rate). The prevalence rate of intimate partner abuse at some stage in the woman's life was 35.1%; 19.5% had experienced actual physical abuse in the past year; and 3.7% had experienced forced sexual intercourse in the past year. Of the latter, in over half of the

cases, this may have resulted in the current pregnancy. A total of 6.6% of women in this study are currently living in fear.

Discussion The anonymity of the survey and the method of implementation encouraged an excellent response rate. The prevalence of physical abuse was higher than that reported in previous studies, however the prevalence of sexual abuse was lower. Up to 2% of requests for TOP could have been due to recent forced sexual intercourse.

Conclusions Many women requesting a TOP have been, or still are, in violent relationships. Some women may attend with an unwanted conception following sexual assault by their current or previous intimate partner.

Key message points

- The impact of intimate partner abuse results in many women accessing the health service.
- The decision to terminate a pregnancy may be due to pressure from the woman's partner.
- Health professionals should be aware that a woman's attendance for a termination of pregnancy may not be her choice.

Context

Intimate partner abuse is a continuum of controlling and abusive behaviour that may become worse over time. It can be defined as 'any violence between current or former partners in an intimate relationship, wherever and whenever the violence occurs. The violence can include physical, sexual, emotional or financial abuse'.¹

A social taboo, intimate partner abuse has only recently been recognised as having a detrimental effect on the mental and physical health of an individual. In addition to the physical injury, many abused women also experience psychological problems including low self-esteem, anxiety and depression, passivity and learned helplessness.² Furthermore, women in such abusive relationships are at risk of sexual violence including forced anal, oral and vaginal intercourse and, in extreme cases, enforced prostitution.³ The deleterious effects of abuse make it a significant contributing factor to women accessing the health care system.

Within the UK we have a diversity of cultures. Rape within marriage remains a tolerated phenomenon in many cultures. Indeed, it only became a criminal offence in England and Wales in 1992. In spite of this legal condemnation, it remains a crime that is difficult to detect or prove. Furthermore, a woman may not conceptualise her experience as rape even though the event itself may meet the legal requirements for such a classification. Rape, particularly marital rape, continues to be under-reported and unlikely to result in prosecution, thus being functionally condoned.

Many women in abusive relationships fear an unwanted pregnancy and therefore choose contraception with maximum efficacy. It has been shown that men are reluctant to use contraceptives that might interfere with their sexual desire or pleasure, thus leaving the responsibility for contraception with the woman.⁴ Many women may wish to control their own fertility, but for women living with an abusive partner the choice of contraception and family spacing may not be her own.

Abortion was legalised in the UK in 1967, but still remains a difficult issue to discuss. One study demonstrated that 23% of women undergoing termination of pregnancy (TOP) were doing so due to their partner's desire to end the pregnancy.⁵ Another study demonstrated a direct correlation between rapid repeat pregnancies amongst adolescents and experiences of abuse in low-income groups.⁶

Objectives

Our main objectives were as follows:

1. To identify the number of women seeking TOP who have experienced intimate partner abuse during their lifetime;
2. To identify the number of women seeking TOP who have experienced physical or sexual abuse during the last 12 months;
3. To explore the nature of the disclosed abuse;
4. To ascertain the number of unwanted pregnancies that have resulted from sexual assault; and
5. To ascertain any association between domestic abuse and characteristics such as age and employment status.

Design

All women attending the pregnancy counselling clinic over a 7-month time period were invited to participate in the survey. Following a routine scan to establish gestation, a pregnancy advisor interviewed each woman. Should the woman choose to proceed with a termination, a nurse undertakes a preoperative assessment. During this assessment, the woman is unaccompanied and so this time was chosen to invite women to participate in the survey. Anonymity was assured and verbal consent obtained. A self-administered questionnaire was completed in private at the end of this consultation. This was then placed in a preaddressed envelope for return to the research unit via the clinic nurse. A list of support and advice agencies accompanied each questionnaire.

In order to provide appropriate support to any woman who chose to disclose abuse and ask for help at that time, the nurse involved in the clinic received additional training. In addition, the researcher maintained a high profile within the clinic throughout the duration of the research.

The chosen tool for quantitative data collection was the Abuse Assessment Screen (AAS),⁷ developed by the nursing research consortium.⁸ It uses five closed questions to assess past and recent history of abuse and its nature. The reliability of the AAS has been demonstrated to be equivalent to the Conflict Tactic Scale.⁹ In addition, women were given an opportunity to add any free text comments they chose to make, on the reverse of the forms.

Results were analysed using the Statistics Package for Social Sciences (SPSS) (SPSS Inc., Chicago, IL, USA) and Pearson Chi-square test to examine any statistical association between the variables being studied.

Ethical issues

Wirral Ethics Committee granted ethical approval for the study. Written consent was not obtained as it was felt that a written consent form, normally stored within the patient case sheet, would introduce unnecessary risks to the woman's safety, particularly if discovered by her partner. Continued support was available during the study from the research team, which was experienced in supporting women who disclose abuse.

Setting and participants

The setting was a pregnancy counselling clinic located within a large district general hospital in the north west of England.

A sample of 312 consecutive women attending the clinic to request a TOP were invited to participate in the research. There were no exclusions.

Results

The majority (96.7%) of women agreed to complete the questionnaire (n = 302). Due to the nature of the clinic, most women attending were under 25 years of age (55.3%, n = 167), with the majority being under 35 years (85.7%, n

Table 1 Lifetime experience of physical or emotional abuse: the perpetrators

Perpetrator of abuse	n	%
Current intimate partner (i.e. husband, boyfriend)	26	24.5
Ex-partner	22	20.8
Stranger	12	11.3
Other	5	4.7
Missing data	41	38.7
Total	106	100.0

= 259). There was a mixture of employed women (52.7%, n = 159), unemployed/housewives (26.1%, n = 79) and students (16.8%, n = 51).

Lifetime experience of physical or emotional abuse

Overall, 35.1% (n = 106, 95% CI 29.8%–40.4%) of women disclosed a lifetime history of emotional or physical abuse. The age or ethnicity of the women were not found to be statistically significant factors. The difference in employment status of the woman was not a significant factor (p = 0.42), with 32%–44% of women in each employment category experiencing abuse. Although some data are missing, it is still clear that the current or former partner was the most commonly declared perpetrator (Table 1). Of the women who reported a lifetime prevalence of abuse, 24.5% were still with the partner responsible.

Using a body map, women were asked to describe the nature and frequency of their abuse. Of the 106 women who experienced abuse, 44% (n = 47) experienced physical assault with or without a weapon to the head area, and 8.8% (n = 9) received injury to their genital area. Almost all had experienced actual physical violence in the form of punching, kicking, cuts, burns, fractures or the use of a weapon. This was in addition to threats and emotional abuse.

Actual physical abuse within the last year

Some 19.5% of the total sample (n = 59, 95% CI 14.9%–24.0%) identified that actual physical abuse had occurred within the last year. Again, the current or former intimate partner was most frequently the perpetrator. In 39% of cases the woman was still with the partner.

Current physical abuse

Due to the nature of the clinic, it is the norm for patients to receive an appointment within a 1–2-week timeframe. Patients were asked if they had experienced actual physical abuse during this timeframe. Five women declared experiencing actual physical violence during this time period. In two cases this was from a current intimate partner, in two cases it was from an ex-intimate partner and in one case the perpetrator was another member of the family.

Sexual abuse

All of the women in this study were requesting TOP. A total of 3.7% (n = 11, 95% CI 1.5%–5.9%) declared that they had experienced forced sexual intercourse in the last year. In just 5/11 (45%) cases this was not thought to be associated with the current pregnancy.

The perpetrators of this forced sexual intercourse within the last year were reported to be current husband or partner (27.3%), ex-husband or partner (27.3%), stranger (18.1%) and other person known to the woman but not a family member (27.3%).

Living in fear

All women were asked if they were afraid of anyone. Twenty (6.6%) women from this total sample stated that they were afraid. Of these women, 90% had been physically abused at some time and 45% had been physically abused in the last year.

It was these responders who often gave incomplete replies. Although they disclosed abuse – sometimes giving accounts of severe and long-standing physical and sexual abuse over many years – they were reluctant to disclose the identity of the abuser.

Discussion

In this study the rate of physical abuse was found to be 35.1%. This is higher than that found in other studies.^{10,11} However, the rate of sexual abuse in this study was surprisingly lower than rates demonstrated in a similar Canadian study.¹² It should be noted that this study only explored sexual abuse in the past 12 months, thus excluding any childhood history of abuse.

Intimate partner abuse is a difficult subject to address, particularly when the woman attends a clinic of this nature. However, an awareness of these issues may encourage professionals to include discussion of such emotive issues when appropriate.

In this survey, 3.7% of the women attending the clinic for TOP had experienced recent forced sexual intercourse. Only 45% of these women were sure that the current pregnancy was not associated with that experience. Several studies have explored the prevalence rates of intimate partner abuse in a more general population^{9,11} and as such their findings have greater generalisability. However, relatively few studies have investigated a specific population and the corresponding health consequences. In this study, from the total sample more than one in three women had experienced abuse during their lifetime. Almost one in five women had been physically assaulted in the past year. Almost 2% of the requests for TOP may have been due to forced sexual intercourse. If these results are representative of a national situation, the implications for the health of women, their families and for health service provision need to be considered.

Conclusions

Physical abuse is common amongst women seeking a TOP. Often the perpetrator of the abuse is their current partner. Numerous factors compound to prevent a woman from leaving these types of relationships. The nature of such relationships often means a progressive increase in emotional, physical and sexual violence.¹ Even if the woman does leave, she is still open to physical and sexual abuse from her ex-partner, as demonstrated in this survey. Some data are missing from this study: the women disclosed some information, but not all. They told us they were experiencing severe physical abuse, but not who from. This may be due to fear that the perpetrator will discover the woman's disclosure.

Health professionals need to be aware of the potentially negative aspects of abortion on women's mental health, coupled with the fact that the woman's presence at the clinic may not be her decision. Sexual assault may have resulted in the unwanted pregnancy or the decision to abort may be associated with pressure from the woman's partner. Due to the significant psychological and physical morbidity associated with induced abortion, it is imperative to consider these issues when supporting women in this situation. Therefore when counselling the woman, the facilitator should take a proactive approach and consider the possibility of intimate partner abuse. Effective support and information about resources may then be offered.

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