assess use of this questionnaire in routine practice, amongst all clients attending the service, rather than to investigate the effects sociodemographic data have on the levels of agreement. The USA study, however, found no statistical difference in agreement between the responses in subgroups of age, income, education and prior contraceptive use.[9]

Another important consideration is to ensure there is standardisation of what is being measured. For example, clinicians may differ in their criteria for a diagnosis of hypertension.[10] Surprisingly, despite clear local guidelines, both the cases in our study where the clinician reported high blood pressure as a risk factor had neither a history of hypertension nor elevated blood pressure readings documented in the client case notes.

As the questionnaires were linked to and part of the case notes, the person responsible for data collection and analysis (JSD) was not blinded to which clinician saw each client. This is a limitation of our study as, for example, assumptions could be made on the accuracy of risk factor identification depending on the level of a clinician's experience.

Benefits of a self-completed questionnaire include increased client participation during the history taking process, more complete client records, standardisation in the recording of client information, minimal interview bias and the clinician identification of additional medical problems that may not be noted during a consultation.[11] It can make it easy to audit the service guidelines and enable a long-term research study on changes in health in long-term CHC users. For women established on CHC with no risk factors, a self-taken history can speed up consultations. There is also scope to develop roles for health care assistants. They could record the client's blood pressure and BMI, check the self-completed history questionnaire, and if there is no indication to refer to a doctor or a nurse, then they could issue the CHC to clients under patient group direction. Our study showed that it is feasible to record history this way and that it is acceptable to clients.

Conclusions

A self-completed history questionnaire could be a valuable tool to potentially improve the care given to established CHC users in contraceptive clinics. Our study has shown that clients can complete a history questionnaire with a high degree of reliability. Discrete questions that ask about a clinical outcome, a disease or whether an event has occurred (e.g. thrombosis) rather than a behaviour (e.g. smoking) or a symptom (e.g. menstrual bleeding patterns) yield a greater agreement between the client and the clinician. In further research, subjective history questions should be worded in such a way as to obtain an unambiguous yes/no answer. Further work needs to assess the impact the questionnaire has on service delivery, such as the effect on consultation times. Use of this tool could be explored in other settings such as general practice and pharmacies, as well as for clients requesting CHC for the first time or for clients established on CHC in other services.

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BOOK REVIEW

Stolen Tomorrows: Understanding and Treating Women's Childhood Sexual Abuse. S Levenkron, A Levenkron. New York, NY: W W Norton, 2007. ISBN: 0-393-06086-1. Price: £16.99. Pages: 288 pages (hardcover)

It's always worth celebrating an addition to the coverage of therapy for abuse survivors. When this addition is written well, sensitively and by an experienced expert in the field, that's even more cause for celebration.

Steven Levenkron, already known for his work on self-harm and eating disorders – his celebrity patients included Karen Carpenter – now focuses his attention on the issue of abuse. *Stolen Tomorrows*, written with his wife Abby, also a therapist, fulfils all of the above criteria, and consists of a series of 19 extended case histories with comment, with supporting sections on the causes, progression and treatment of female childhood abuse. It's an insightful work, and therapists both new to and working in the field will find it useful, particularly if they wish to have a window into what happens in the counselling room. Non-therapists who work with abuse survivors will also benefit from that window, as well as gaining a good overview of what can be done in a therapeutic context were they to refer on.

So where's my flinch, for flinch there is. I have no doubts about this book's appropriateness to the professional reader. But then I turn to the back cover – and I read the advertising blurb on several bookstore websites and the reviews quoted on the author's own site – and that's where I have my reservations. For the book claims to be appropriate for the abuse survivor, and that it will help such 'victims' seek help for 'their secret shame'.

That may have been the book's aim, but it's not what it has achieved. The case histories are moving, but accompanied by objective and entirely therapy-aimed commentaries that might well frighten any but the most informed, educated and therapeutically advanced client. At the end of the 276 pages, the four and a half pages aimed at such clients seem like – and perhaps are – an afterthought, and though compassionate, by no means comprehensive or sufficient. None of this would matter had the book been advertised as being for a therapy market. But to major on its use to survivors of abuse seems to me to be inaccurate and unfortunate.

Final verdict? If you are a therapist, absolutely buy it for your own library and recommend it to colleagues. But on no account give it to your clients until the work you are doing with them is complete and they can take a long view.

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