I am 58 now, an early baby boomer. I am astonished at the changes that have occurred in women’s healthcare in my lifetime. I remember that my mom was shocked when our family doctor taught me to do a breast exam when I turned 18. What a farsighted man. Information on sexually transmitted infections was not as generally available. AIDS was beyond our imagination. Contraceptive options were more limited although the pill was gaining in popularity. Menopause seemed like the end of life—menopausal women were old. Today more and more of us women are becoming savvy healthcare consumers. We have more information, we have treatment options, we decide our own care. I think this is the most exciting change of all!

—Alice

LEARNING OBJECTIVES

- Summarize information that women may need to implement effective self-care measures for dealing with menstruation.
- Contrast dysmenorrhea and premenstrual syndrome.
- Compare the advantages, disadvantages, and effectiveness of the various methods of contraception available today.
- Delineate basic gynecologic screening procedures indicated for well women.
- Discuss the physical and psychologic aspects of menopause.
- Explain the cycle of violence and its application to battered women, including pregnant women.
- Delineate the nurse’s role in working with women who have experienced intimate partner violence or rape.

MEDIA LINK

CD-ROM
- NCLEX-RN® Review
- Audio Glossary
- Skill 2-2: Assisting with a Pelvic Examination
- Animation: Oral Contraceptive

Companion Website
- NCLEX-RN® Review
- Case Study
- Thinking Critically
A woman’s healthcare needs change throughout her lifetime. As a young girl she needs health teaching about menstruation, sexuality, and personal responsibility. As a teen she needs information about reproductive choices and safe sexual activity. During this time she should also be introduced to the importance of healthcare practices such as breast self-examination and regular Pap smears. The mature woman may need to be reminded of these self-care issues and prepared for the physical changes that accompany childbirth and aging. By educating women about their bodies, their healthcare choices, and their right to be knowledgeable consumers, nurses can help women assume responsibility for the healthcare they receive. This chapter provides information about selected aspects of women’s healthcare with an emphasis on conditions typically addressed in a community-based setting.

**NURSING CARE IN THE COMMUNITY**

*Women's health* refers to a holistic view of women and their health-related needs within the context of their everyday lives. It is based on the awareness that a woman’s physical, mental, and spiritual status are interdependent and affect her state of health or illness. The woman’s view of her situation, her assessment of her needs, her values, and her beliefs are valid and important factors to be incorporated into any healthcare intervention.

Nurses can work with women to provide health teaching and information about self-care practices in schools, during routine examinations in a clinic or office, at senior centers, at meetings of volunteer organizations, through classes offered by local agencies or schools, or in the home. This community-based focus is the key to providing effective nursing care to women of all ages.

In reality the vast majority of women’s healthcare is provided outside of acute care settings. Nurses oriented to community-based care are especially effective in recognizing the autonomy of each individual and in dealing with clients holistically. This holistic approach is important in addressing not only physical problems but also major health issues such as violence against women, which may go undetected unless care providers are alert for signs of it. See “Developing Cultural Competence.”

**DEVELOPING CULTURAL COMPETENCE**

**NURTURING A THERAPEUTIC RELATIONSHIP**

In the course of your work as a nurse, you are bound to encounter people different from you. Even with the best of intentions, you may say or do something your client or the client's family finds offensive or inappropriate. If you ask someone something and get a funny look, ask what's on the person's mind. The answer may surprise you. It often leads to more honest reporting of information and a feeling of being listened to and respected. When people feel emotionally safe, cultural and other perceived differences shrink. This helps a therapeutic relationship to develop between the person you are serving and you, yourself, as the caregiver.

**THE NURSE’S ROLE IN ADDRESSING ISSUES OF SEXUALITY**

Because sexuality and its reproductive implications are such intrinsic and emotion-laden parts of life, people have many concerns, problems, and questions about sex roles, behaviors, education, inhibitions, morality, and...
related areas such as family planning. The reproductive implications of sexual intercourse must also be considered. Some people desire pregnancy; others wish to avoid it. Health factors are another consideration. The increase in the incidence of sexually transmitted infections, especially HIV/AIDS and herpes, has caused many people to modify their sexual practices and activities. Women frequently ask questions or voice concerns about these issues to the nurse in a clinic or ambulatory setting. Thus, the nurse may need to assume the role of counselor or educator on sexual and reproductive matters.

Nurses who assume this role must recognize their own feelings, values, and attitudes about sexuality so they can be more sensitive when they encounter the values and beliefs of others. Nurses need to have accurate, up-to-date information about anatomy and physiology and about topics related to sexuality, sexual practices, and common gynecologic problems. In addition, when a woman is accompanied by her partner, it is important that the nurse be sensitive to the dynamics of the relationship between the two.

TAKING A SEXUAL HISTORY

Nurses are often responsible for taking a woman’s initial history, including her gynecologic and sexual history. For the interview to be its most useful, the nurse must have effective communication skills and should conduct the interview in a quiet, private place free of distractions. It is important to phrase questions in a sensitive and non-judgmental manner and to assure the woman of strict confidentiality.

Opening the discussion with a brief explanation of the purpose of such questions is often helpful. For example, the nurse might say, “As your nurse, I’m interested in all aspects of your well-being. Often women have concerns or questions about sexual matters, especially when they are pregnant (or starting to be sexually active). I will be asking you some questions about your sexual history as part of your general health history.”

It may be helpful to use direct eye contact as much as possible unless the nurse knows it is culturally unacceptable to the woman. The nurse should do little, if any, writing during the interview, especially if the woman seems ill at ease or is discussing very personal issues. Beginning with general questions such as, “What brings you here today?” before progressing to more sensitive topics will provide an opportunity for the woman to develop trust with the nurse. Open-ended questions are often useful in eliciting information. For example, “What, if anything, would you change about your sex life?” will elicit more information than “Are you happy with your sex life now?” The nurse needs to clarify terminology and proceed from easier topics to those that are more difficult to discuss.

Throughout the interview the nurse should be alert to body language and nonverbal cues. It is important that the nurse not assume that the client is heterosexual. Some women are open about lesbian relationships; others are more reserved until they develop a sense of trust in their caregivers.

After completing the sexual history, the nurse assesses the information obtained. If there is a problem that requires further medical tests and assessments, the nurse refers the woman to a nurse practitioner, certified nurse-midwife, physician, or counselor as necessary. In many instances the nurse alone will be able to develop a nursing diagnosis and then plan and implement therapy. The nurse must be realistic in making assessments and planning interventions. It requires insight and skill to recognize when a woman’s problem requires interventions that are beyond a nurse’s preparation and ability. In such situations it is essential that the nurse makes appropriate referrals.

MENSTRUATION

Girls today begin to learn about puberty and menstruation at a young age. Unfortunately, the source of their “education” is sometimes their peers or the media; thus, the information is often incomplete, inaccurate, and sensationalized. Nurses who work with young girls and adolescents recognize this and are working hard to provide accurate health teaching and to correct misinformation about menstruation (the onset of menses) and the menstrual cycle.

Cultural, religious, and personal attitudes about menstruation are part of the menstrual experience and often reflect negative attitudes toward women. Currently in the Western world, there are few customs associated with menstruation. In many cultures, sexual intercourse during menses is a common practice. Physiologically, it is not generally contraindicated. For most couples the decision is one of personal preference. (The physiology of menstruation is discussed in Chapter 3.

Counseling the Premenstrual Girl about Menarche

Many young women find it embarrassing to discuss menstruation, both because of the taboos associated with the subject and because of their immaturity. However, the most critical factor in successful adaptation to menarche is the adolescent’s level of preparedness. Information should be given to premenstrual girls over time rather than all at once. This allows them to absorb information and develop questions.

The following basic information is helpful for young clients:

- **Cycle length.** Cycle length is determined from the first day of one menses to the first day of the next menses.
Initially a female’s cycle length is about 29 days, but the normal length may vary from 21 to 35 days. As a woman matures, cycle length often shortens to a median of 25+ days just before menopause. Cycle length frequently varies by a day or two from one cycle to the next, although greater normal variations may also occur.

- **Amount of flow.** The average flow is approximately 25 to 60 mL per period. Usually women characterize the amount of flow in terms of the number of pads or tampons used. Flow is often heavier at first and lighter toward the end of the period.
- **Length of menses.** Menses usually lasts from 2 to 8 days, although this may vary.

The nurse should make it clear that variations in age at menarche, length of cycle, and duration of menses are normal, because girls may worry if their experience varies from that of their peers. It also is helpful to acknowledge the negative aspects of menstruation (messiness, cramping, embarrassment) while stressing its positive role as a symbol of maturity and womanhood.

### EDUCATIONAL TOPICS

#### Pads and Tampons

Since early times women have made pads and tampons from cloth or rags, which required washing but were reusable. Commercial tampons were introduced in the 1930s.

Today adhesive-stripped minipads and maxipads and flushable tampons are readily available. However, the deodorants and increased absorbency that manufacturers have added to both pads and tampons may prove harmful. The chemical used to deodorize can create a rash on the vulva and damage the tender mucous lining of the vagina. Excessive or inappropriate use of tampons can produce dryness or even small sores or ulcers in the vagina.

Because the use of superabsorbent tampons has been linked to the development of toxic shock syndrome (TSS), women should avoid using them (see Care of the Woman with Toxic Shock Syndrome in Chapter 5). They should use regular absorbency tampons only for heavy menstrual flow (during the first 2 or 3 days of the period), not during the whole period, and change them every 3 to 6 hours. Because *Staphylococcus aureus*, the causative organism of TSS, is frequently found on the hands, a woman should wash her hands before inserting a fresh tampon and should avoid touching the tip of the tampon when unwrapping it or before insertion.

In the absence of a heavy menstrual flow, tampons absorb moisture, leaving the vaginal walls dry and subject to injury. The absorbency of regular tampons varies. If the tampon is hard to pull out or shreds when removed, or if the vagina becomes dry, the tampon is probably too absorbent.

A woman may want to use tampons only during the day and switch to pads at night to avoid vaginal irritation. She should avoid using tampons on the last, spotty days of her period and should never use them for midcycle spotting or leukorrhea. If a woman experiences vaginal irritation, itching, or soreness or notices an unusual odor while using tampons, she should stop using them or change brands or absorbencies to see if that helps.

#### Vaginal Spray, Douching, and Cleansing

Vaginal sprays are unnecessary and can cause infections, itching (pruritus), burning, vaginal discharge, rashes, and other problems. If a woman chooses to use a spray, she needs to know that these sprays are for external use only and should never be applied to irritated or itching skin or used with pads.

Although douching is sometimes used to treat vaginal infections, douching as a hygiene practice is unnecessary since the vagina cleanses itself. Douching washes away the natural mucus and upsets the vaginal ecology, which can make the vagina more susceptible to infection. Perfumed douches can cause allergic reactions, and too frequent use of an undiluted or strong douche solution can cause irritation or even tissue damage. Propelling water up the vagina may also erode the antibacterial cervical plug and force bacteria and germs from the vagina into the uterus. Women should avoid douching during menstruation because the cervix is dilated to permit the downward flow of menstrual fluids from the uterine lining. Douching may force tissue back up into the uterine cavity, which could contribute to endometriosis.

The mucous secretions that bathe the vagina are odor-free while they are in the vagina; odor develops only when they mingle with perspiration and are exposed to the air. Keeping one’s skin clean and free of bacteria with plain soap and water is the most effective method of controlling odor. A soapy finger or soft washcloth should be used to wash gently between the vulvar folds. Bathing is as important during menses as at any other time. A long, leisurely soak in a warm tub promotes menstrual blood flow and relieves cramps by relaxing the muscles.

Keeping the vulva fresh throughout the day means keeping it dry and clean. A woman can ensure adequate ventilation by wearing cotton panties and clothes loose enough to permit the vaginal area to “breathe.” After using the toilet, a woman should always wipe herself from front to back and, if necessary, follow up with a moistened paper towel or toilet paper. If an unusual odor persists despite these efforts, it may be a sign that something is awry. Certain conditions such as vaginitis produce a foul-smelling discharge.

#### ASSOCIATED MENSTRUAL CONDITIONS

A variety of menstrual irregularities have been identified. An abnormally short duration of menstrual flow is termed
Dysmenorrhea; an abnormally long one is called hypermenorrhea. Excessive, profuse flow is called menorrhagia, and bleeding between periods is known as metrorrhagia. Infrequent and too frequent menses are termed oligomenorrhea and polymenorrhea, respectively. An anovulatory cycle is one in which ovulation does not occur. (Note: Anovulatory cycles often occur during the first year after menarche and during the perimenopause, the period around the time of menopause.) Generally menstrual irregularities should be investigated to rule out disease.

Amenorrhea

Amenorrhea, the absence of menses, is classified as primary or secondary. Primary amenorrhea exists if menstruation has not been established by 16 years of age or within 4 years of breast development. Secondary amenorrhea exists when an established menses (of longer than 3 months) ceases for at least 6 months.

Primary amenorrhea necessitates a thorough assessment of the young woman to determine its cause. Possible causes include congenital obstructions, Turner syndrome, congenital absence of the uterus, testicular feminization (external genitals appear female but uterus and ovaries are absent and testes are present), or absence or imbalance of hormones. Treatment depends on the causative factors. Some causes are not correctable.

Secondary amenorrhea is caused most frequently by pregnancy. Additional causes include lactation, hormonal imbalances, poor nutrition (anorexia nervosa, obesity, and fad dieting), ovarian lesions, strenuous exercise (associated with long-distance runners, dancers, and other athletes with low body fat ratios), debilitating systemic diseases, stress of high intensity or long duration, stressful life events, a change in season or climate, use of oral contraceptives, which block ovulation; prostaglandin inhibitors (such as ibuprofen, aspirin, and naproxen), which act as prostaglandin inhibitors; and self-care measures such as regular exercise, rest, heat, and good nutrition. Biofeedback has also been used with some success.

Secondary dysmenorrhea is associated with pathology of the reproductive tract and usually appears after menstruation has been established. Conditions that most frequently cause secondary dysmenorrhea include endometriosis; residual pelvic inflammatory disease; anatomic anomalies such as cervical stenosis, imperforate hymen, and uterine displacement; ovarian cysts; and the presence of an intrauterine device. Because primary and secondary dysmenorrhea may coexist, accurate differential diagnosis is essential for appropriate treatment.

Some nutritionists suggest that vitamins B and E help relieve the discomforts associated with menstruation. Vitamin B₆ may help relieve the premenstrual bloating and irritability some women experience. Vitamin E, a mild prostaglandin inhibitor, may help decrease menstrual discomfort. Avoiding salt can decrease discomfort from fluid retention.

Heat is soothing and promotes increased blood flow. Any source of warmth, from sipping herbal tea to soaking in a hot tub or using a heating pad, may be helpful during painful periods. Massage can also soothe aching back muscles and promote relaxation and blood flow.

Regular exercise can ease menstrual discomfort and help prevent cramps and other menstrual complaints. Aerobic exercises such as jogging, cycling, swimming, and fast-paced walking are especially helpful. Persistent discomfort should be medically evaluated.

Premenstrual Syndrome

Premenstrual syndrome (PMS) refers to a symptom complex associated with the luteal phase of the menstrual cycle (2 weeks prior to the onset of menses). The symptoms must, by definition, occur between ovulation and the onset of menses. They repeat at the same stage of each menstrual cycle and include some or all of the following:

- **Psychologic:** irritability, lethargy, depression, low morale, anxiety, sleep disorders, crying spells, hostility
- **Neurologic:** classic migraine, vertigo, syncope
- **Respiratory:** rhinitis, hoarseness, and occasionally asthma
■ Gastrointestinal: nausea, vomiting, constipation, abdominal bloating, craving for sweets
■ Urinary: retention, oliguria
■ Dermatologic: acne
■ Mammary: swelling and tenderness

Most women experience only some of these symptoms. The symptoms usually are most pronounced 2 or 3 days before the onset of menstruation and subside as menstrual flow begins, with or without treatment. Premenstrual dysphoric disorder (PMDD) is a diagnosis that may be applied to a subgroup of women with PMS whose symptoms are primarily mood related and severe.

The exact cause of PMS is unknown, although a variety of theories have been put forth to explain it. These include, for example, hormone imbalance, nutritional deficiency, prostaglandin excess, and endorphin deficiency. PMS may also be related to serotonin because serotonin levels in women with PMS fall after ovulation (Hudson, 2002).

Nursing Management. The nurse can help the woman identify specific symptoms and develop healthy behavior. After assessment, counseling for PMS may include advising the woman to restrict her intake of foods containing methylxanthines such as chocolate, cola, and coffee; restrict her intake of alcohol, nicotine, red meat, and foods containing salt and sugar; increase her intake of complex carbohydrates and protein; and increase the frequency of meals. For women whose primary symptoms are psychologic, supplementation with B-complex vitamins, especially B6, may decrease anxiety and depression. Vitamin E supplements may help reduce breast tenderness. Supplementation with 1200 mg calcium daily may help relieve certain symptoms, including negative mood, food cravings, water retention, and pain (Hudson, 2002).

A program of aerobic exercise such as fast walking, jogging, and aerobic dancing is generally beneficial. In addition to vitamin supplements, pharmacologic treatments for PMS include diuretics and prostaglandin inhibitors. Serotonin agents such as fluoxetine hydrochloride (Prozac) and sertraline hydrochloride (Zoloft) may help relieve symptoms of PMDD. For women who are not planning a pregnancy, low-dose combined oral contraceptives, which suppress ovulation, are often helpful.

A woman benefits a great deal from an empathetic relationship with a healthcare professional to whom she feels free to voice concerns. Encourage the woman to keep a diary to help identify life events associated with PMS. Self-care groups and self-help literature both help women feel they have control over their bodies. Some women use complementary therapies such as homeopathic remedies or herbs. It is important that women using such alternatives seek advice from knowledgeable, experienced homeopaths or herbalists.

CONTRACEPTION

The decision to use a method of contraception may be made individually by a woman (or, in the case of vasectomy, by a man) or jointly by a couple. The decision may be motivated by a desire to avoid pregnancy, to gain control over the number of children conceived, or to determine the spacing of future children. In choosing a specific method, consistency of use outweighs the absolute reliability of the given method.

Decisions about contraception should be made voluntarily, with full knowledge of available choices, advantages, disadvantages, effectiveness, side effects, contraindications, and long-term effects. Many outside factors influence this choice, including cultural practices, religious beliefs, attitudes and personal preferences, cost, effectiveness, misinformation, practicality of method, and self-esteem. Different methods of contraception may be appropriate at different times for individuals or couples.

FERTILITY AWARENESS METHODS

Fertility awareness methods, also known as natural family planning, are based on an understanding of the changes that occur throughout a woman’s ovulatory cycle. All these methods require periods of abstinence and recording of certain events throughout the cycle; cooperation of the partners is important.

Fertility awareness methods are free, safe, and acceptable to many whose religious beliefs prohibit other methods. They provide an increased awareness of the body, involve no artificial substances or devices, encourage a couple to communicate about sexual activity and family planning, and are useful in helping a couple plan a pregnancy.

On the other hand, these methods require extensive initial counseling to be used effectively. They may interfere with sexual spontaneity; they require extensive maintenance of records for several cycles before beginning to use them; they may be difficult or impossible for women with irregular cycles to use; and, although theoretically they should be very reliable, in practice they may not be as reliable in preventing pregnancy as other methods.

The basal body temperature (BBT) method to detect ovulation requires that a woman take her BBT every morning upon awakening (before any activity) and record the readings on a temperature graph. To do this she uses a BBT thermometer, which shows tenths of a degree rather than the two tenths shown on standard thermometers. She may also use tympanic thermometry (an “ear thermometer”). After 3 to 4 months of recording temperatures, a woman
with regular cycles should be able to predict when ovulation will occur. The method is based on the fact that the temperature sometimes drops just before ovulation and almost always rises and remains elevated for several days after. The temperature rise occurs in response to the increased progesterone levels that occur in the second half of the cycle. Figure 4–1 shows a sample BBT chart. To avoid conception the couple abstains from intercourse on the day of the temperature rise and for 3 days after. Because the temperature rise does not occur until after ovulation, a woman who had intercourse just before the rise is at risk of pregnancy. To decrease this risk, some couples abstain from intercourse for several days before the anticipated time of ovulation and then for 3 days after.

The calendar, or rhythm, method is based on the assumptions that ovulation tends to occur 14 days (plus or minus 2 days) before the start of the next menstrual period, sperm are viable for 48 to 72 hours, and the ovum is viable for 24 hours. To use this method, the woman must record her menstrual cycles for 6 to 8 months to identify the shortest and longest cycles. The first day of menstruation is the first day of the cycle. The fertile phase is calculated from 18 days before the end of the shortest recorded cycle through 11 days from the end of the longest recorded cycle. For example, if a woman’s cycle lasts from 24 to 28 days, the fertile phase would be calculated as day 6 through day 17. Once this information is obtained, the woman can identify the fertile and infertile phases of her cycle. For effective use of this method, she must abstain from intercourse during the fertile phase. The calendar method is the least reliable of the fertility awareness methods and has largely been replaced by other, more scientific approaches.

The cervical mucus method, sometimes called the ovulation method or the Billings method, involves the assessment of cervical mucus changes that occur during the menstrual cycle. The amount and character of cervical mucus change because of the influence of estrogen and progesterone. At the time of ovulation, the mucus (estrogen-dominant mucus) is clearer, more stretchable (a quality called spinnbarkeit), and more permeable to sperm. It also shows a characteristic fern pattern when placed on a glass slide and allowed to dry (see Figure 6–3, page 129). During the luteal phase, the cervical mucus is thick and sticky (progesterone-dominant mucus) and forms a network that traps sperm, making their passage more difficult.

To use the cervical mucus method, the woman abstains from intercourse for the first menstrual cycle. Each day she assesses her cervical mucus for amount, feeling of slipperness or wetness, color, clearness, and spinnbarkeit, as she becomes familiar with varying characteristics.

The peak day of wetness and clear, stretchable mucus is assumed to be the time of ovulation. To use this method correctly, the woman should abstain from intercourse from the time she first notices that the mucus is becoming clear, more elastic, and slippery until 4 days after the last wet mucus (ovulation) day. Because this method evaluates the effects of hormonal changes, it can be used by women with irregular cycles.

The symptothermal method consists of various assessments made and recorded by the couple. These include information regarding cycle days, coitus, cervical mucus changes, and secondary signs such as increased libido, abdominal bloating, mittelschmerz (midcycle abdominal pain), and BBT. Through the various assessments, the couple learns to recognize signs that indicate ovulation. This combined approach tends to improve the effectiveness of fertility awareness as a method of birth control.

**FIGURE 4–1**

Sample basal body temperature chart.
SITUATIONAL CONTRACEPTIVES

Abstinence can be considered a method of contraception, and, partly because of changing values and the increased risk of infection with intercourse, it is gaining increased acceptance.

Coitus interruptus, or withdrawal, is one of the oldest and least reliable methods of contraception. This method requires that the male withdraw from the female's vagina when he feels that ejaculation is impending. He then ejaculates away from the external genitalia of the woman. Failure tends to occur for two reasons: (1) this method demands great self-control on the part of the man, who must withdraw just as he feels the urge for deeper penetration with impending orgasm, and (2) some pre-ejaculatory fluid, which can contain sperm, may escape from the penis during the excitement phase prior to ejaculation. The fact that the quantity of sperm in this pre-ejaculatory fluid is increased after a recent ejaculation is especially significant for couples who engage in repeated episodes of intercourse within a short period of time. Couples who use this method should be aware of postcoital contraceptive options in case the man fails to withdraw in time.

Douching after intercourse is an ineffective method of contraception and is not recommended. It may actually facilitate conception by pushing sperm farther up the birth canal.

SPERMICIDES

Spermicides, available as creams, jellies, foams, vaginal film, and suppositories, are inserted into the vagina before intercourse. They destroy sperm or neutralize vaginal secretions and thereby immobilize sperm. Spermicides that effervesce in a moist environment offer relatively rapid protection, and coitus may take place immediately after they are inserted. Suppositories may require up to 30 minutes to dissolve and will not offer protection until they do so. The woman should be instructed to insert these spermicide preparations high in the vagina and maintain a supine position.

Spermicides are minimally effective when used alone, but their effectiveness increases in conjunction with a diaphragm or condom. The major advantages of spermicides are their wide availability and low toxicity. Skin irritation and allergic reactions to spermicides are the primary disadvantages. Spermicides do not offer protection against the organisms that cause gonorrhea and chlamydia, or against the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS) (Centers for Disease Control and Prevention [CDC], 2002).

BARRIER METHODS OF CONTRACEPTIVES

Barrier methods of contraception prevent the transport of sperm to the ovum, immobilize sperm, or are lethal against sperm.

Male and Female Condoms

The male condom offers a viable means of contraception when used consistently and properly (Figure 4–2). Acceptance has been increasing as a growing number of men...
are assuming responsibility for regulation of fertility. The condom is applied to the erect penis, rolled from the tip to the end of the shaft, before vulvar or vaginal contact. A small space must be left at the end of the condom to allow for collection of the ejaculate, so that the condom will not break at the time of ejaculation. If the condom or vagina is dry, a water-soluble lubricant such as K-Y jelly should be used to prevent irritation and possible condom breakage.

Couples should be careful when removing the condom after intercourse. For optimal effectiveness the man should withdraw his penis from the woman's vagina while it is still erect and hold the condom rim to prevent spillage. If after ejaculation the penis becomes flaccid while still in the vagina, the man should hold onto the edge of the condom while withdrawing to avoid spilling semen and to prevent the condom from slipping off.

The effectiveness of male condoms is largely determined by their use. The condom is small, disposable, and inexpensive; it has no side effects, requires no medical examination or supervision, and offers visual evidence of effectiveness. Most condoms are made of latex, although polyurethane and silicone rubber condoms are available for individuals allergic to latex. All condoms, except natural “skin” condoms, made from lamb's intestines, offer protection against both pregnancy and sexually transmitted infections (STIs). Breakage, displacement, perineal or vaginal irritation, and dulled sensation are possible disadvantages.

The male condom is becoming increasingly popular because of the protection it offers from infections. For women, sexually transmitted infection increases the risk of pelvic inflammatory disease (PID) and resultant infertility. Many women are beginning to insist that their sexual partners use condoms, and many women carry condoms with them.

The Reality female condom (Figure 4–3) is a thin polyurethane sheath with a flexible ring at each end. The inner ring, at the closed end of the condom, serves as the means of insertion and fits over the cervix like a diaphragm. The second ring remains outside the vagina and covers a portion of the woman's perineum. It also covers the base of the man's penis during intercourse. Available over the counter and designed for one-time use, the condom may be inserted up to 8 hours before intercourse. The inner sheath is prelubricated but does not contain spermicide and is not designed to be used with a male condom. Data on its effectiveness against pregnancy are still limited, although the female condom is slightly less reliable than the diaphragm, male condom, vaginal sponge, and cervical cap (Sobrero, 2002). Because it also covers a portion of the vulva, it probably provides better protection than other methods against some pathogens. High cost, noisiness during intercourse, and the cumbersome feel of the device make acceptability a problem for some couples.

**Diaphragm and Cervical Cap**

The **diaphragm** (Figure 4–4) is used with spermicidal cream or jelly and offers a good level of protection from conception. The woman must be fitted with a diaphragm and instructed in its use by trained personnel. The diaphragm should be rechecked for correct size after each childbirth and whenever a woman has gained or lost 15 lb or more.

The diaphragm must be inserted before intercourse, with approximately 1 teaspoon (or 1.5 inches from the tube) of spermicidal jelly placed around its rim and in the cup. This chemical barrier supplements the mechanical barrier of the diaphragm. The diaphragm is inserted through the vagina and covers the cervix. The last step in insertion is to push the edge of the diaphragm under the symphysis pubis, which may result in a “popping” sensation. When fitted properly and correctly in place, the diaphragm should not cause discomfort to the woman or her partner. Correct placement of the diaphragm can be checked by touching the cervix with a fingertip through the cup. The cervix feels like a small, firm, rounded structure and has a consistency similar to that of the tip of the nose. The center of the diaphragm should be over the cervix. If more than 4 hours elapse between insertion of the diaphragm and intercourse, additional spermicidal cream or jelly should be used. It is necessary to leave the diaphragm in place for at least 6 hours after coitus. The diaphragm should then be removed, cleaned with mild soap and water, and allowed to air dry before it is stored in its case. If intercourse is desired again within the 6 hours, another type of contraception must be used or additional spermicidal jelly placed in the vagina with an applicator, taking care not to disturb the placement of the diaphragm. Periodically the diaphragm should be held up to the light and inspected for tears or holes.

Some couples feel that the use of a diaphragm interferes with the spontaneity of intercourse. The nurse can suggest that the partner insert the diaphragm as part of foreplay. The woman can then easily verify the placement herself.

Diaphragms are an excellent contraceptive method for women who are lactating, who cannot or do not wish to use the pill (oral contraceptives), who are smokers over age 35, or who wish to avoid the increased risk of PID associated with intrauterine devices.

Women who object to manipulating their genitals to insert the diaphragm, check its placement, and remove it may find this method unsatisfactory. It is not recommended for women with a history of urinary tract infection, because pressure from the diaphragm on the urethra may interfere with complete bladder emptying and lead to recurrent urinary tract infections. Women with a history of toxic shock syndrome should not use diaphragms or any of...
The female condom. To insert the condom:

A. Remove condom and applicator from wrapper by pulling up on the ring.
B. Insert condom slowly by gently pushing the applicator toward the small of the back.
C. When properly inserted, the outer ring should rest on the folds of skin around the vaginal opening, and the inner ring (closed end) should fit loosely against the cervix.

FIGURE 4–3

A, The female condom. To insert the condom: B, Remove condom and applicator from wrapper by pulling up on the ring. C, Insert condom slowly by gently pushing the applicator toward the small of the back. D, When properly inserted, the outer ring should rest on the folds of skin around the vaginal opening, and the inner ring (closed end) should fit loosely against the cervix.

The barrier methods because they are left in place for prolonged periods. For the same reason, the diaphragm should not be used during a menstrual period or if a woman has abnormal vaginal discharge.

The cervical cap (Figure 4–5) is a cup-shaped device, used with spermicidal cream or jelly, that fits snugly over the cervix and is held in place by suction. Effectiveness rates and method of insertion are similar to those for the diaphragm. Although the cap may be left in place for up to 48 hours, most caregivers recommend that it not be left in place for more than 24 hours. Advantages, disadvantages, and contraindications are similar to those associated with the diaphragm. The cervical cap may be more difficult to fit because of limited size options. It also tends to be more difficult for women to insert and remove.

Lea’s shield is a reusable, silicone rubber device shaped like an elliptic bowl. It is similar to the cervical cap but contains a centrally located valve that permits the passage of cervical secretions and air. It can be used for up to 24 hours with a single application of spermicide. The device has
FIGURE 4–4

Inserting the diaphragm. A, Apply jelly to the rim and center of the diaphragm. B, Insert the diaphragm. C, Push the rim of the diaphragm under the symphysis pubis. D, Check placement of the diaphragm. Cervix should be felt through the diaphragm.

FIGURE 4–5

A cervical cap. The vaginal sponge is again available in the United States. It is a pillow-shaped, soft, absorbent synthetic sponge containing spermicide that is available over the counter. It is made with a concave or cupped area on one side that fits over the cervix. It has a loop for easy removal. The sponge is moistened thoroughly with water before insertion to activate the spermicide and then inserted into the vagina with the cupped side against the cervix (Figure 4–6). It should be left in place for 6 hours following intercourse and may be worn for up to 24 hours, then removed and discarded.

Advantages include the following: professional fitting is not required, it may be used for multiple acts of coitus for up
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to 24 hours, one size fits all, and it acts as both a barrier and a spermicide. Disadvantages include cost (about $30 for a 12-pack), problems associated with removing it, and irritation or allergic reactions. Research indicates that the sponge is less effective than the diaphragm at preventing pregnancy, and women using the sponge are more likely than diaphragm users to stop using their method of contraception (Kuyoh, Toroitich-Ruto, Grimes, Schulz et al., 2003).

Intrauterine Devices
The **intrauterine device (IUD)** is designed to be inserted into the uterus by a qualified healthcare provider and left in place for an extended period, providing continuous contraceptive protection. Traditionally the IUD was believed to act by preventing the implantation of a fertilized ovum. Thus, the IUD was considered an abortifacient (abortion-causing) method. This belief is not accurate. IUDs truly are contraceptives; they trigger a spermicidal type reaction in the body, thereby preventing fertilization. The IUD is also known to have local inflammatory effects on the endometrium.

Advantages of the IUD include high rate of effectiveness, continuous contraceptive protection, no coitus-related activity, and relative inexpensiveness over time. Possible adverse reactions to the IUD include discomfort to the wearer, increased bleeding during menses, PID, perforation of the uterus, intermenstrual bleeding, dysmenorrhea, and expulsion of the device.

Two IUDs are currently available in the United States. The copper T380A (ParaGard) is highly effective and can be left in place for up to 10 years. The levonorgestrel-releasing intrauterine system (LNG-IUS) (Mirena), which releases levonorgestrel gradually, is comparable in effectiveness to the copper T and may be left in place for up to 5 years (Figure 4–7). The primary advantage of the LNG-IUS is that it produces diminished periods or even amenorrhea, which women welcome once they are advised that the absence of menses is safe and not an indication of pregnancy.

IUDs are recommended only for women who have at least one child and are in a monogamous relationship, because these women have the lowest risk of developing a pelvic infection. It is not recommended for women with multiple sexual contacts, because they are at higher risk for sexually transmitted infections.

The IUD is inserted into the uterus with its string or tail protruding through the cervix into the vagina. It may be inserted during a menstrual period or during the 4- to 6-week postpartum check. After insertion the clinician instructs the woman to check for the presence of the string once a week for the first month and then after each menses. She is told that she may have some cramping or bleeding intermittently for 2 to 6 weeks and that her first few menses may be irregular. Follow-up examination is suggested 4 to 8 weeks after insertion.

Women with IUDs should contact their healthcare providers if they are exposed to an STI or if they develop the following warning signs: late period, abnormal spotting or bleeding, pain with intercourse, abdominal pain, abnormal discharge, signs of infection (fever, chills, and malaise), or missing string. If the woman becomes pregnant with an IUD in place, the device is generally removed if the string is visible.

**HORMONAL CONTRACEPTION**

Hormonal contraceptives are available in a variety of forms. They may be progestin-only hormones, most often
using a synthetic form of progesterone called progestin, or a combination of estrogen and a progestin.

**Combined Estrogen-Progestin Approaches**

Combined hormonal approaches work by inhibiting the release of an ovum, by creating an atrophic endometrium, and by maintaining thick cervical mucus that slows sperm transport and inhibits the process that allows sperm to penetrate the ovum.

**Combined Oral Contraceptives**. Combined oral contraceptives (COCs), also called birth control pills, are typically a combination of the hormones estrogen and progesterone. COCs are safe, highly effective, and rapidly reversible. Many COCs are available. The pill is taken daily for 21 days, typically beginning on the Sunday after the first day of the menstrual cycle. In most cases menses occurs 1 to 4 days after the last pill is taken. Seven days after taking her last pill, the woman restarts the pill. Thus the woman always begins the pill on the same day. Some companies offer a 28-day pack with seven “blank” pills so that the woman never stops taking a pill. The pill should be taken at approximately the same time each day—usually upon arising or before retiring in the evening.

Recently discussion has focused on “extended” or continuous use of COCs (without the 7 contraception-free days). When COCs are taken all the time, women have far fewer bleeding days and often cease having periods. The continuous approach also makes it easier for some women to use COCs correctly because they do not have to think about whether to take a pill. Research indicates that there is no increase in pathologic changes or adverse side effects with continuous use (Zite, Gilliam, & Darney, 2004). Seasonale, the first extended-cycle COC approved by the U.S. Food and Drug Administration (FDA), is now available by prescription. Seasonale is a 91-day regimen in which a woman takes an active tablet daily for 84 consecutive days followed by 7 days of inactive tablets during which the woman has a period. Using Seasonale a woman has only 4 periods a year. Pregnancy prevention rates and risks are comparable to those of other COCs (Reuters Health Information, 2003).

Although they are highly effective when taken correctly, COCs may produce a variety of side effects, which may be either progestogen or estrogen related (Table 4–1). The use of low-dose (35 mcg or less estrogen) preparations has reduced many of the side effects. The newer 20-mcg pills have even fewer side effects, but they may result in less contraceptive effectiveness.

**Contraindications to the use of COCs include pregnancy, previous history of thrombophlebitis or thromboembolic disease, acute or chronic liver disease of cholestatic type with abnormal function, presence of estrogen-dependent carcinomas, undiagnosed uterine bleeding, heavy smoking, gallbladder disease, hypertension, diabetes, and hyperlipidemia. In addition, women with the following relative contraindications who use COCs need to be monitored frequently: migraine headaches, epilepsy, depression, oligomenorrhea, and amenorrhea. Women who choose this method of contraception should be fully advised of its potential side effects.

COCs also have some important noncontraceptive benefits. Many women experience relief of uncomfortable menstrual symptoms. Cramps are lessened, flow is decreased, and cycle regularity is increased. Mittelschmerz is eliminated, and the incidence of functional ovarian cysts is decreased. More important, there is a substantial reduction in the incidence of ectopic pregnancy, ovarian cancer, endometrial cancer, iron deficiency anemia, and benign breast disease. In addition, COCs are considered a good solution to the physiologic problems some women experience during the perimenopause. Because of the increased risk of myocardial infarction (heart attack), women over age 35 who smoke should not take COCs.

The woman using COCs should contact her healthcare provider if she becomes depressed, becomes jaundiced, develops a breast lump, or experiences any of the following warning signs: severe abdominal pain, severe chest pain or shortness of breath, severe headaches, dizziness, changes in vision (vision loss or blurring), speech problems, or severe leg pain.

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**TABLE 4–1 Side Effects Associated with Oral Contraceptives**

<table>
<thead>
<tr>
<th>Estrogen Effects</th>
<th>Progestin Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alterations in lipid metabolism</td>
<td>Acne, oily skin</td>
</tr>
<tr>
<td>Breast tenderness, engorgement; increased breast size</td>
<td>Breast tenderness; increased breast size</td>
</tr>
<tr>
<td>Cerebrovascular accident</td>
<td>Decreased libido</td>
</tr>
<tr>
<td>Changes in carbohydrate metabolism</td>
<td>Decreased high-density lipoprotein (HDL) cholesterol levels</td>
</tr>
<tr>
<td>Chloasma (Melasma)</td>
<td>Depression</td>
</tr>
<tr>
<td>Fluid retention; cyclic weight gain</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Headache</td>
<td>Hirsutism</td>
</tr>
<tr>
<td>Hepatic adenomas</td>
<td>Increased appetite; weight gain</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Increased low-density lipoprotein (LDL) cholesterol levels</td>
</tr>
<tr>
<td>Leukorrhea, cervical erosion, ectopia</td>
<td>Oligomenorrhea, amenorrhea</td>
</tr>
<tr>
<td>Nausea</td>
<td>Pruritus</td>
</tr>
<tr>
<td>Nervousness, irritability</td>
<td>Sebaceous cysts</td>
</tr>
<tr>
<td>Telangiectasia</td>
<td></td>
</tr>
<tr>
<td>Thromboembolic complications—thrombophlebitis, pulmonary embolism</td>
<td></td>
</tr>
</tbody>
</table>
Another oral contraceptive is the progesterone-only pill, also called the minipill. It is used primarily by women who have a contraindication to the estrogen component of the combination pills, such as history of thrombophlebitis, but are strongly motivated to use this form of contraception. The major problems with this preparation are amenorrhea or irregular spotting and bleeding patterns.

**Other Combined Hormonal Methods.** Hormones can now be administered transdermally using a *contraceptive skin patch* called Ortho Evra, which releases a combination of norelgestromin and ethinyl estradiol. The patch is roughly the size of a silver dollar, but square. The woman applies the patch to the abdomen, buttocks, trunk, or upper outer arm and wears it continuously for 1 week. This routine is followed for 3 weeks; no patch is applied for the fourth week. During the treatment-free week, the woman menstruates. The patch is highly effective in women who weigh less than 198 lb. The patch is as safe and reliable as COCs and has a better rate of compliance.

*NuvaRing vaginal contraceptive ring* (manufactured by Organon), another form of low-dose, sustained-release hormonal contraceptive, is a flexible soft ring that the woman inserts into her vagina (Figure 4–8 ). The ring is left in place for 3 weeks and then removed for 1 week to allow for withdrawal bleeding. One size fits virtually all women. The ring is highly effective and has minimal side effects. The ring can be worn during intercourse and is comfortable for both the woman and her partner. However, the woman should be advised to use a backup form of contraceptive for one week if she removes the ring from her vagina for more than 3 hours (Zite et al., 2004).

*Lunelle*, an injectable combination of medroxyprogesterone acetate (MPA) and estradiol cypionate (E₂C), is administered every 28 to 30 days (not to exceed 33 days) intramuscularly. Lunelle is a highly effective contraceptive that has a side-effect pattern similar to that of COCs. Lunelle was withdrawn from the U.S. market in 2002.

**Long-Acting Hormonal Contraceptives**

*Subdermal implants* are not currently available in the United States. Norplant is a system consisting of six Silastic capsules containing levonorgestrel, a progestin, which are implanted in the woman’s arm. It is available in over 50 countries worldwide. Norplant prevents ovulation in most women. It also stimulates the production of thick cervical mucus, which inhibits sperm penetration. Norplant provides effective, continuous contraception separate from the act of coitus. In other words, the woman does not have to insert a device or barrier for each act of intercourse. Possible side effects include spotting, irregular bleeding or amenorrhea, an increased incidence of ovarian cysts, weight gain, headaches, fluid retention, acne, mood changes, and depression.

U.S. distribution of Norplant was voluntarily suspended by its manufacturer, Wyatt Pharmaceuticals. Wyatt has received FDA approval for a two-rod version of Norplant called Jadelle, which is used in many countries, but the company has no plans to market Jadelle in the United States. A single-rod, highly effective system called Implanon, manufactured by Organon, is used by 1 million European women. It may become available in the United States in the near future (Zite et al., 2004).

Depot-medroxyprogesterone acetate (DMPA) (*Depo-Provera*), another long-acting progestin, suppresses ovulation for 3 months when given as a single injection of 150 mg. DMPA provides levels of progesterone high enough to block the luteinizing hormone (LH) surge, thereby suppressing ovulation. It also thickens the cervical mucus to block sperm penetration. Side effects include menstrual irregularities, headache, weight gain, breast tenderness, and depression. Prolonged use has been associated with significant, long-term loss of bone density, and many physicians have stopped prescribing it because of this. It should not be used for long-term birth control (longer than 2 years) unless other methods of birth control are not adequate. Return of fertility may be delayed for an average of 9 months.
EMERGENCY POSTCOITAL CONTRACEPTION

Emergency contraception is indicated when a woman is worried about pregnancy because of unprotected intercourse or possible contraceptive failure (e.g., broken condom, slipped diaphragm, or too long a time between DMPA injections). Two product kits, Preven, a combined hormonal approach (levonorgestrel/ethinyl estradiol), and Plan B, a progestin-only approach (levonorgestrel), are now FDA approved for emergency contraception.

Though sometimes called the “morning-after pill,” the phrase is misleading because the woman actually takes a dose as soon after intercourse as possible and a second dose 12 hours later. This regimen must be started within 72 hours after unprotected intercourse; the earlier the treatment is started, the greater the effectiveness.

OPERATIVE STERILIZATION

Operative sterilization refers to surgical procedures that permanently prevent pregnancy. Before sterilization is performed on either partner, the physician provides a thorough explanation of the procedure to both. Each needs to understand that sterilization is not a decision to be taken lightly or entered into when psychologic stresses, such as separation or divorce, exist. Even though both male and female procedures are theoretically reversible, the permanency of the procedure should be stressed and understood.

Male sterilization is achieved through a relatively minor procedure called a vasectomy. This procedure involves surgically severing the vas deferens in both sides of the scrotum. Following vasectomy it takes about 4 to 6 weeks and 6 to 36 ejaculations to clear the remaining sperm from the vas deferens. During that period the couple is advised to use another method of birth control and to bring in two or three semen samples for a sperm count. The man is rechecked at 6 and 12 months to ensure that fertility has not been restored by recanalization. Side effects of a vasectomy include pain, infection, hematoma, sperm granulomas, and spontaneous reanastomosis (reconnecting).

Vasectomies can sometimes be reversed by using microsurgery techniques. Restored fertility, as measured by subsequent pregnancy, ranges from 30% to 76%, depending primarily on the length of time between vasectomy and reversal (Pollack & Barone, 2000).

Female sterilization is most frequently accomplished by tubal ligation. The tubes are located through a small subumbilical incision or by minilaparotomy techniques and are crushed, ligated, electrocoagulated, banded, or plugged (in the newer, reversible procedures). Tubal ligation may be done at any time. However, the postpartum period is an ideal time to perform a tubal ligation because the tubes are somewhat enlarged and easily located.

Complications of female sterilization procedures include coagulation burns on the bowel, bowel perforation, pain, infection, hemorrhage, and adverse anesthesia effects. Reversal of a tubal ligation depends on the type of procedure performed. With microsurgical techniques a pregnancy rate of 44% to 81% is possible (DeLeon & Peters, 2000).

MALE CONTRACEPTION

The vasectomy and the condom, discussed previously, are currently the only forms of male contraception available in the United States. Hormonal contraception for men has yet to be developed, although studies are under way.

NURSING MANAGEMENT

In most cases the nurse who provides information and guidance about contraceptive methods works with the female partner, because most contraceptive methods are female oriented. Because men can purchase condoms without seeing a healthcare provider, counseling and interaction with a nurse are required only with vasectomy. As a nurse, you can play an important role in helping a woman choose a method of contraception acceptable to her and to her partner.

In addition to completing a history and assessing for any contraindications to specific methods, spend time with a woman learning about her lifestyle, personal attitudes about particular contraceptive methods, religious beliefs, personal biases, and plans for future childbearing, before helping the woman select a particular contraceptive method. Once the method is chosen, help the woman learn to use it effectively. Table 4–2 summarizes factors to consider in choosing an appropriate method of contraception.

<table>
<thead>
<tr>
<th>TABLE 4–2 Factors to Consider in Choosing a Method of Contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness of method in preventing pregnancy</strong></td>
</tr>
<tr>
<td><strong>Safety of the method:</strong></td>
</tr>
<tr>
<td>Are there inherent risks?</td>
</tr>
<tr>
<td>Does it offer protection against STIs or other conditions?</td>
</tr>
<tr>
<td><strong>Client’s age and future childbearing plans</strong></td>
</tr>
<tr>
<td>Any contraindications in client’s health history</td>
</tr>
<tr>
<td>Religious or moral factors influencing choice</td>
</tr>
<tr>
<td>Personal preferences, biases</td>
</tr>
<tr>
<td><strong>Lifestyle:</strong></td>
</tr>
<tr>
<td>How frequently does client have intercourse?</td>
</tr>
<tr>
<td>Does she have multiple partners?</td>
</tr>
<tr>
<td>Does she have ready access to medical care in the event of complications?</td>
</tr>
<tr>
<td>Is cost a factor?</td>
</tr>
<tr>
<td>Partner’s support and willingness to cooperate</td>
</tr>
<tr>
<td>Personal motivation to use method</td>
</tr>
</tbody>
</table>
TEACHING HIGHLIGHTS

USING A METHOD OF CONTRACEPTION

- Discuss factors a woman should consider in choosing a method of contraception (see Table 4-2). Note that different methods may be appropriate at different times in a woman's life.
- Review the woman's reasons for choosing a particular method and confirm the absence of any contraindications to specific methods.
- If a technique is to be learned, such as charting BBT or inserting a diaphragm, demonstrate and then have the woman do a return demonstration as appropriate.
- Provide information on what the woman should do if unusual circumstances arise (for example, she misses a pill or forgets a morning temperature). These can be presented in a written handout as well.
- Stress warning signs that may require immediate action by the woman and explain why these signs indicate a risk.
- Arrange to talk with the woman again soon, either by phone or at a return visit, to see if she has any questions or has encountered any problems.

Also review any possible side effects and warning signs related to the method chosen and counsel the woman about what action to take if she suspects she is pregnant. In many cases the nurse is involved in telephone counseling of women who call with questions and concerns about contraception. Thus, it is vital to be knowledgeable about this topic and have resources available to find answers to less common questions. “Teaching Highlights: Using a Method of Contraception” provides guidelines for helping women use a method of contraception effectively.

CLINICAL INTERRUPTION OF PREGNANCY

Although abortion was legalized in the United States in 1973, controversy over moral and legal issues continues. Many people are opposed to abortion for religious, ethical, or personal reasons. Others feel that access to a safe, legal abortion is every woman's right. A number of physical and psychosocial factors influence a woman's decision to seek an abortion. Some situations may involve lack of knowledge about contraceptive options, contraceptive failure, rape, or incest.

Mifepristone (Mifeprrex), originally called RU-486, may be used to induce a medical abortion during the first 7 weeks of pregnancy (up to 49 days following conception). Mifepristone blocks the action of progesterone, thereby altering the endometrium. After the length of the woman's gestation is confirmed, she takes a dose of mifepristone. Two days later she returns to her caregiver and takes a dose of the prostaglandin misoprostol, which induces contractions that expel the embryo/fetus. About 12 days after taking the misoprostol, the woman is seen a third time to confirm that the abortion was successful.

Surgical abortion in the first trimester is technically easier and safer than abortion in the second trimester. It may be performed by dilation and curettage (D&C), minisuction, or vacuum curettage. Second-trimester abortion may be done using dilation and evacuation (D&E), hypertonic saline, systemic prostaglandins, and intrauterine prostaglandins.

Nursing Management

Important aspects of nursing care for a woman who decides to have an abortion include providing information about the methods of abortion and associated risks; counseling regarding available alternatives to abortion and their implications; encouraging verbalization by the woman; providing counseling and emotional support before, during, and after the procedure; monitoring vital signs, intake, and output; providing for physical comfort and privacy throughout the procedure; and health teaching about self-care, the importance of the postabortion checkup, and contraception review.

HEALTH PROMOTION FOR WOMEN

Health care providers and consumers alike are becoming increasingly aware of the importance of activities that promote health and prevent illness, including lifestyle choices. In addition, the value of regular screenings to detect any health problems early cannot be overemphasized. Health screening recommendations vary by age. General screening and immunization guidelines for women can be found on the Companion Website.

This section focuses on some of the most commonly used screening procedures: breast self-examination and breast examination by a trained healthcare provider, mammography, Pap smear, and pelvic examination.

BREAST EXAMINATION

Like the uterus, the breast undergoes regular cyclic changes in response to hormonal stimulation. Each month, in rhythm with the cycle of ovulation, the breasts become engorged with fluid in anticipation of pregnancy, and the woman may experience sensations of tenderness, lumpiness, or pain. If conception does not occur, the accumulated fluid drains away via the lymphatic network. Mastodynia (premenstrual swelling
and tenderness of the breasts) is common. It usually lasts for 3 to 4 days before the onset of menses, but the symptoms may persist throughout the month.

After menopause, adipose breast tissue atrophies and is replaced by connective tissue. Elasticity is lost, and the breasts may droop and become pendulous. The recurring breast engorgement associated with ovulation ceases. If estrogen replacement therapy is used to counteract other symptoms associated with menopause, breast engorgement may resume.

Monthly breast self-examination (BSE) is the best method for detecting breast masses early. A woman who knows the texture and feel of her own breasts is far more likely to detect changes that develop. Thus, it is important for a woman to develop the habit of doing routine BSE as early as possible, preferably as an adolescent. Women at high risk for breast cancer are especially encouraged to be attentive to the importance of early detection through routine BSE.

The effectiveness of BSE is determined by the woman’s ability to perform the procedure correctly. She should do a BSE on a regular monthly basis about 1 week after each menstrual period, when the breasts are typically not tender or swollen. After menopause she should perform BSE on the same day each month (as chosen by the woman). See “Teaching Highlights: Breast Self-Examination.”

Clinical breast examination by a trained healthcare provider, such as a physician, nurse practitioner, or nurse-midwife, is an essential element of a routine gynecologic examination. Experience in differentiating among benign, suspicious, and worrisome breast changes lets the caregiver reassure the woman if the findings are normal or move forward with additional diagnostic procedures or referral if the findings are suspicious or worrisome.

### Mammmography

A mammogram is a soft-tissue x-ray of the breast without the injection of a contrast medium. It can detect lesions in the breast before they can be felt and has gained wide acceptance as an effective screening tool for breast cancer. Currently the American Cancer Society recommends that all women age 40 and over have an annual mammogram. The National Cancer Institute and the American College of Obstetricians and Gynecologists (ACOG) recommend mammograms every 1 to 2 years for women ages 40 to 49 and annually for all women age 50 and older.

### PAP Smear and Pelvic Examination

The Papanicolaou test (Pap smear), a form of cervical cytolgoy testing, has helped dramatically decrease the incidence of death from cervical cancer. Its purpose is to detect cellular abnormalities by examining a smear containing cells from the cervix and the endocervical canal. A newer test, the ThinPrep Pap smear, is proving even more effective than the traditional Pap smear in detecting abnormalities. In this test, no slide is prepared. Instead the cervical cells, gathered in the same way as for the Pap smear, are transferred directly to a vial of preservative fluid, thereby preserving the entire specimen.

Whenever you teach about pelvic examination and Pap smear, be sure the woman understands that she should not douche for at least 24 hours beforehand. Douching can interfere with the accuracy of the Pap smear. Occasionally a caregiver will specifically request that a woman use a douche before a Pap smear; douching should only be done in this circumstance.

For best test results, also advise women to avoid intercourse and the use of other female hygiene products and spermicidal agents immediately before a specimen is obtained. Specimens should not be obtained during menstruation or when visible cervicalitis exists.

The pelvic examination lets the healthcare provider assess a woman’s vagina, uterus, ovaries, and lower abdominal area. It is often performed after the Pap smear but may also be performed without a Pap for diagnostic purposes. Women sometimes perceive the pelvic examination as uncomfortable and embarrassing. The negative feelings may cause women to delay having yearly gynecologic examinations, and this avoidance may pose a threat to life and health.

To make the pelvic examination less threatening and thus improve health-seeking behavior, caregivers can offer the woman a mirror to watch the procedure, point out anatomic parts to her, and position and drape her to allow eye-to-eye contact with the practitioner.
Begin by discussing the risk factors associated with breast cancer and the use of BSE in breast cancer detection. Then describe and demonstrate the correct procedure for BSE.

1. **Timing**—Instruct the woman to perform BSE on a monthly basis. Be specific based on whether she is premenopausal, pregnant, postmenopausal, or postmenopausal receiving hormone therapy.

2. **Inspection**—Instruct the woman to inspect her breasts by standing or sitting in front of a mirror. She should inspect them in three positions: both arms relaxed at her sides, both arms raised straight over her head, and both hands placed on her hips while she leans forward (Figure 4–9). In these positions she should do the following:
   - Note size and symmetry of the breasts. Some size difference between breasts is normal. Breasts may vary but the variations should remain constant during rest or movement—note abnormal contours.
   - Note shape and direction of breasts. Breasts can be rounded or pendulous with some variation between breasts. Breasts should point slightly laterally.
   - Observe for color and venous patterns. Check for redness or inflammation. A blue hue with a marked venous pattern that is focal or unilateral may indicate an area of increased blood supply due to tumor. Symmetric venous patterns are normal.
   - Observe for thickening or edema. Skin edema is seen as thickened skin with enlarged pores ("orange peel"). It may indicate blocked lymph drainage due to tumor.
   - Note the surface of the skin. Skin dimpling, puckering, or retraction when the hands are pressed together or against the hips suggests malignancy. Striae (stretch marks) are normal.
   - Note nipple size, shape, and direction. Long-standing nipple inversion is normal, but an inverted nipple previously capable of erection is suspicious. Note any deviation, flattening, or broadening of the nipples.
   - Check for rashes, ulcerations, or discharge.
3. Palpation—Instruct the woman to palpate (feel) her breasts as follows:
   - Lie down. Put one hand behind your head. With the other hand, fingers flattened, gently feel your breast. Press lightly (Figure 4–10A).
   - Figure 4–10B shows you how to check each breast. Begin as you see in B and follow the arrows, feeling gently for a lump or thickening. Remember to feel all parts of each breast, including the “tail” of tissue near the armpit. Repeat the process on the second breast.
   - Now repeat the same process on each breast sitting up, with your hand still behind your head (Figure 4–10C).
   - Squeeze the nipple between your thumb and forefinger. Look for any discharge—clear, bloody, or milky (Figure 4–10D).

4. Take the woman’s hand and help her identify her “normal bumps” (e.g., mammary ridge, ribs, nodularity in the upper, outer quadrants).

5. Determine whether she has any questions about her findings during this examination. If she has questions, palpate the area and attempt to identify whether it is normal.

6. If a breast model is available, give the woman the opportunity to palpate it and identify the lumps.

7. Provide her with a monthly reminder such as an American Cancer Society shower card.

**TEACHING HIGHLIGHTS—continued**

Caregivers can encourage the woman to participate by asking questions and giving feedback.

Nurse practitioners, certified nurse-midwives, and physicians all perform pelvic examinations. Nurses assist the practitioner and the woman during the examination. See “Skill 2-2: Assisting with a Pelvic Examination” in the Clinical Skills Manual, as well as the accompanying CD-ROM.

**MENOPAUSE**

Menopause, the time when menses cease, is a time of transition for a woman, marking the end of her reproductive abilities. Climacteric, or change of life (often used synonymously with menopause), refers to the psychologic and physical alterations that occur around the time of
menopause. Today the median age at menopause is 51.3 years, and the average life span of a woman in the United States is over 80 years. Thus the average woman will live one third of her life after menopause. A woman’s psychological adaptation to menopause and the climacteric is multifactorial. She is influenced by her own expectations and knowledge, physical well-being, family views, marital stability, and sociocultural expectations. As the number of women reaching menopause increases, the negative emotional connotations society once attached to menopause are diminishing, enabling menopausal women to cope more effectively and even encouraging them to view menopause as a time of personal growth.

Perimenopause is the term applied to the period preceding menopause, usually about 2 to 8 years, when ovarian function wanes and hormonal deficiencies begin to produce symptoms. Contraception remains a concern during perimenopause. Combined oral contraceptives are becoming increasingly popular among healthy nonsmokers because many women also benefit from the noncontraceptive effects, including regulation of menses, relief of symptoms of estrogen deficiency, and a decreased risk of endometrial and ovarian cancers. Other contraceptive options for perimenopausal women include the contraceptive patch, the vaginal ring, IUDs, progestin-only methods, and barrier methods such as condoms, diaphragm, cervical cap, and spermicides.

The physical characteristics of menopause are linked to the shift from a cyclic to a noncyclic hormonal pattern. The age at onset may be influenced by nutritional, cultural, or genetic factors. The onset of menopause occurs when estrogen levels become so low that menstruation stops.

Generally, ovulation ceases 1 to 2 years before menopause, but individual variations exist. Atrophy of the ovaries occurs gradually. Follicle-stimulating hormone levels rise, and less estrogen is produced. Menopausal symptoms include atrophic changes in the vagina, vulva, and urethra and in the trigonal area of the bladder.

Many menopausal women experience a vasomotor disturbance commonly known as hot flashes, a feeling of heat arising from the chest and spreading to the neck and face. The hot flashes are often accompanied by sweating and sleep disturbances. These episodes may occur as often as 20 to 30 times a day and generally last 3 to 5 minutes. Some women also experience dizzy spells, palpitations, and weakness. Many women find their own most effective ways to deal with the hot flashes. Some report that using a fan or drinking a cool liquid helps relieve distress; others seek relief through hormone replacement therapy. In addition, many women use complementary therapies (see later discussion).

The uterine endometrium and myometrium atrophy, as do the cervical glands. The uterine cavity constricts. The fallopian tubes and ovaries atrophy extensively. The vaginal mucosa becomes smooth and thin, and the rugae disappear, leading to loss of elasticity. As a result, intercourse can be painful, but this problem may be overcome by using lubricating gel. Dryness of the mucous membrane can lead to burning and itching. The vaginal pH level increases as the number of Döderlein’s bacilli decreases.

Postmenopausal women can still be multiorgasmic. Some women find that their sexual interest and activity improve as the need for contraception disappears and personal growth and awareness increase. Other women experience a decrease in libido at this time. Vulvar atrophy occurs late, and the pubic hair thins, turns gray or white, and may ultimately disappear. The labia shrink and lose their heightened pigmentation. Pelvic fascia and muscles atrophy, resulting in decreased pelvic support. The breasts become pendulous and decrease in size and firmness.

Long-range physical changes may include osteoporosis, a decrease in the bony skeletal mass. This change is thought to be associated with lowered estrogen and androgen levels, lack of physical exercise, and a chronic low intake of calcium. Moreover, the estrogen deprivation that occurs in menopausal women may significantly increase their risk of coronary heart disease. Loss of protein from the skin and supportive tissues causes wrinkling. Postmenopausal women frequently gain weight, which may be due to excessive caloric intake or to lower caloric need with the same level of intake.

CLINICAL THERAPY

Hormone Replacement Therapy

Hormone replacement therapy (HRT), usually involving estrogen with or without a progestin, had for years been the treatment of choice for relieving menopausal symptoms, especially hot flashes, night sweats, and urogenital symptoms. HRT has also been recognized as very effective in preventing the development of osteoporosis. Nevertheless in 2002 the advisability of HRT was called into question because of the results of the Women’s Health Initiative (WHI) study, which suggested that the risks of HRT outweigh the benefits, especially for long-term use, because of the slightly increased risk of breast cancer, thromboembolic disease, and stroke (Writing Group for the Women’s Health Initiative Investigations, 2002).

Furthermore the beneficial effect of long-term estrogen use in reducing the incidence of Alzheimer disease (AD) was called into question by the Women’s Health Initiative Memory Study (WHIMS), which found a 105% increase in AD with estrogen use (Shumaker, Legault, Rapp et al., 2003). However, the WHIMS study participants were all 65 years or older when they began therapy. Thus, it is likely that those women already had brain changes related to AD (Gambrell, 2004). Other research about AD risk indicates that the age when estrogen is initiated is crucial. When estrogen is begun...
at menopause and used for more than 10 years, there is a reduction of up to 83% in lifetime risk (Gambrell, 2004; Zandi, Carlson, Plassman et al., 2002).

Consequently the picture about HRT is somewhat clouded. Currently HRT is recognized as the most effective short-term (1 to 2 years) therapy for women who experience severe menopausal symptoms. However, women considering HRT should clearly understand the associated risks so that they can make an informed decision about using it. HRT is not indicated for the prevention of coronary heart disease, and women at risk of osteoporosis should explore alternative treatments (see later discussion).

When estrogen is given alone, it can produce endometrial hyperplasia and increase the risk of endometrial cancer. Thus, in women who still have a uterus, estrogen is opposed by giving a progestin, often Provera, continuously or sequentially. Current research focuses on using lower doses of estrogen (less than 0.625 mg/day); consideration has also been given to using lower doses or less frequent administration of progestins to minimize progestin exposure (Hackley & Rousseau, 2004). Although most women prefer to take estrogen orally, some choose the transdermal estrogen skin patch. Estrogen may also be given by injection. For women experiencing decreased libido, combination estrogen-testosterone preparations are available.

A thorough history, physical examination including Pap smear, and baseline mammogram are indicated before starting HRT. An initial endometrial biopsy is indicated for women with an increased risk of endometrial cancer; biopsy is also indicated if excessive, unexpected, or prolonged vaginal bleeding occurs. Women taking estrogen should be advised to stop immediately if they develop headaches, visual changes, signs of thrombophlebitis, or chest pain.

**Complementary and Alternative Therapies**

For women who do not wish to take HRT or who have medical contraindications to it, a variety of approaches have been proposed as alternative or complementary treatment or preventive measures for the discomforts of the perimenopausal and postmenopausal years. These include diet and nutrition, specifically a high-fiber, low-fat diet with supplements of vitamins D and E. Phytoestrogens (plant substances with estrogen properties) have been used by many women, but recent research has shown that they do not improve hot flashes or other menopausal symptoms (Krebs, Ensrud, MacDonald, & Wilt, 2004). Phytoestrogens are also found in soy products such as soy milk and tofu. Currently the effectiveness of the herbs and soy is receiving considerable study as more and more women elect to use alternative approaches to treat their menopausal symptoms. A recent study concluded that phytoestrogens in soy and red clover extracts do not improve hot flashes or other menopausal symptoms (Krebs, Ensrud, MacDonald, & Wilt, 2004).

**COMPLEMENTARY CARE**

**PHYTOESTROGENS**

Phytoestrogens are naturally occurring plant sterols that have an estrogen-like effect. Herbs that contain phytoestrogen include ginseng, agrus castus, beth root, black cohosh, dong quai, fenugreek, licorice, red sage, sarsaparilla, and wild Mexican yam. Phytoestrogens are also found in soy products such as soy milk and tofu. A recent study concluded that phytoestrogens in soy and red clover extracts do not improve hot flashes or other menopausal symptoms (Krebs, Ensrud, MacDonald, & Wilt, 2004).

**Prevention and Treatment of Osteoporosis**

Osteoporosis is more common in women who are middle-aged or older. In fact, in the United States, 13% to 18% of women age 50 and older have osteoporosis (ACOG, 2004). Risk factors associated with osteoporosis include European American or Asian heritage; small-boned, thin build; low body weight (less than 127 lb); family history of osteoporosis; lack of regular weight-bearing exercise; never pregnant; early onset of menopause; consistently low intake of calcium; cigarette smoking; moderate to heavy alcohol intake; and the use of certain medications such as anticonvulsants, corticosteroids, or lithium.

Bone mineral density (BMD) testing is useful in identifying individuals who are at risk for osteoporosis. ACOG (2004) recommends BMD testing for the following:

- All postmenopausal women age 65 or older
- Postmenopausal women with a fracture
- Postmenopausal women under age 65 with one or more risk factors

A variety of conditions, including malabsorption syndrome, cancer, cirrhosis of the liver, chronic use of cortisone, and rheumatoid arthritis, can cause secondary arthritis, which resembles osteoporosis. If these causes have been eliminated, treatment for osteoporosis is initiated.

Prevention of osteoporosis is a primary goal of care. Women are advised to maintain an adequate calcium intake. Women over age 50 should have a daily calcium intake of 1200 mg. Most women require supplements to achieve

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**Prevention of Osteoporosis**

- **Perimenopausal Care**: Development of up to 83% in lifetime risk (Gambrell, 2004; Zandi, Carlson, Plassman et al., 2002).
- **HRT**: Short-term (1 to 2 years) therapy for severe symptoms, with consideration of risks such as endometrial hyperplasia.
- **Alternatives**: Diet, phytoestrogens, and other herbs (e.g., ginseng, dong quai).

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**Phytoestrogens**

- Naturally occurring plant sterols.
- Found in soy products, such as soy milk and tofu.
-Include ginseng, agrus castus, beth root, black cohosh, dong quai, fenugreek, licorice, red sage, sarsaparilla, and wild Mexican yam.

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**Prevention of Osteoporosis**

- Bone mineral density (BMD) testing.
- Risk factors: European American or Asian heritage, low body weight, family history, lack of weight-bearing exercise, pregnancy history, and certain medications.
- Treatment: Calcium supplements, moderate alcohol intake, and cessation of smoking.
this level. They should also have a daily vitamin D intake of 400 to 800 IU. Women are also advised to participate regularly in exercise, to consume only modest quantities of alcohol and caffeine, and to stop smoking. Alcohol and smoking have a negative effect on the rate of bone resorption. Women’s height should be measured at each visit, because a loss of height is often an early sign that vertebrae are being compressed because of reduced bone mass. See “Evidence-Based Nursing: Prevention of Osteoporosis.”

The effectiveness of estrogen in preventing osteoporosis is well documented. However, because of the increased risks associated with long-term use of hormone replacement therapy, other pharmacologic agents are being used more frequently to prevent and treat osteoporosis. These include the following (Davidson, 2003):

- **Bisphosphonates** are calcium regulators that act by inhibiting bone resorption and increasing bone mass. Alendronate (Fosamax) and risedronate (Actonel) are the two most commonly prescribed.
- **Selective estrogen receptor modulators (SERMs)** such as raloxifene (Evista) preserve the beneficial effects of estrogen, including its protection against osteoporosis, but do not stimulate uterine or breast tissue.
- **Calcitonin** is a calcium regulator that may inhibit bone loss. Generally administered as a nasal spray, although it is also available as an injection, its value is less clear than that of the other medications listed.

**NURSING MANAGEMENT**

Most menopausal women deal well with this developmental phase of life, although some women may need counseling to adjust successfully. Nurses and other health professionals can help menopausal women achieve high-level functioning at this time in life. Of major importance is the nurse’s ability to understand and provide support for the woman’s views and feelings. Use an empathetic approach in counseling, health teaching, and providing physical care.

Explore the question of the woman’s comfort during sexual intercourse. In counseling, it may be appropriate to say, “After menopause many women notice that their vagina seems drier and intercourse can be uncomfortable. Have you noticed any changes?” This gives the woman information and may open discussion. Then go on to explain that dryness and shrinking of the vagina can be addressed by use of a water-soluble jelly. Use of estrogen, orally or in vaginal creams, may also be indicated. Increased frequency of intercourse will maintain some elasticity in the vagina. When assessing the menopausal woman, address the question of sexual activity openly but tactfully, because the woman may have been socialized to be reticent in discussing sex.

**EVIDENCE-BASED NURSING**

**PREVENTION OF OSTEOPOROSIS**

**Clinical Question**
What value does exercise have as an intervention to prevent osteoporosis in postmenopausal women?

**Evidence**
A team of nine medical experts examined 18 randomized controlled trials that met strict criteria for methodological soundness. Additional content experts were consulted in developing the final systematic review. The value of exercise as an intervention for the prevention of postmenopausal bone loss is a controversial subject, and this systematic review evaluated objective evidence about its efficacy. The reviewers concluded that exercise is effective in increasing bone mass density of the spine, hip, and wrist of postmenopausal women.

**Implications**
Aerobic exercises, weight-bearing activity (fast walking), and resistance exercises were all effective in increasing the bone mass density of the spine in postmenopausal women. Walking was effective in increasing bone mass density of the hip. As would be expected, walking had no effect on bone mass density of the wrist, but aerobic exercises had a positive effect. All of the exercise activities were equally effective, so the best advice may be to recommend an exercise regimen that is most similar to normal activities of daily living, (i.e., a walking program). In these studies, exercise programs were not compared to “no exercise at all,” but rather to normal activity, so exercise in addition to normal activities of daily living is required to have a beneficial effect. It is also necessary to stick to an exercise program for the long term, as evidence demonstrated slowing of bone loss after one year or longer of an exercise program.

You should encourage postmenopausal women to use a variety of exercises to prevent the loss of bone mass density during menopause. Although any exercise—aerobic, resistance, or weight bearing—is effective, a walking program may be the most practical. Continue to encourage exercise as a long-term activity as menopause progresses.

**Critical Thinking**
For your clients who cannot bear weight, what exercise would you recommend to prevent the loss of bone mass density? How can you encourage postmenopausal women to stick with an exercise program?

**Reference**
The crucial need of women in the perimenopausal period of life is for adequate information about the changes taking place in their bodies and their lives. Supplying that information provides both a challenge and an opportunity for nurses.

**VIOLENCE AGAINST WOMEN**

Violence against women is a major health concern, one that costs the healthcare system millions of dollars and thousands of lives. Violence affects women of all ages, races, ethnic backgrounds, socioeconomic levels, educational levels, and walks of life. Two of the most common forms of violence are domestic violence and rape. Often people not only accept these forms of violence but also shift the blame to the violence against the women themselves by asking questions such as, “How did she make him so mad?” “Why does she stay?” “What was she doing out so late?” and “Why did she dress that way?”

Violence against women is also a major health concern. In addition to causing injuries, associated physical and mental health outcomes, and fatalities, violence costs the healthcare system millions of dollars annually. In response to this epidemic, healthcare providers are becoming more knowledgeable about actions they should take to identify women at risk, implement preventive measures, and provide effective care.

**DOMESTIC VIOLENCE**

Domestic violence is defined as collective methods used to exert power and control by one individual over another in an adult domestic or intimate relationship. It is also termed intimate partner violence. This section focuses on domestic violence experienced by women in heterosexual relationships, although gay and lesbian individuals do experience domestic violence in their relationships as well.

Domestic violence is staggering commonly in the United States, although the incidence has decreased significantly in the last decade. Currently it accounts for 20% of violent crimes against women (Rennison, 2003). Worldwide as many as one in three women will be the victim of violence or sexual coercion at some point in her life (State of the World Population, 2000).

The woman may be married to her abuser, or she may be living with, dating, or divorced from him. Domestic violence takes many forms, including verbal attacks, insults, intimidation, threats, emotional abuse, social isolation, economic deprivation, intellectual derision, ridicule, stalking, and physical attacks and injury. Physical battering includes slapping, kicking, shoving, punching, forms of torture, attacks with objects or weapons, and sexual assault. Women who are physically abused can also suffer psychologic and emotional abuse.

**Cycle of Violence**

In an effort to explain the experience of battered women, Walker (1984) developed the theory of the cycle of violence. Battering takes place in a cyclic fashion through three phases:

1. In the tension-building phase, the batterer demonstrates power and control. This phase is characterized by anger, arguing, blaming the woman for external problems, and possibly minor battering incidents. The woman may blame herself and believe she can prevent the escalation of the batterer’s anger by her own actions.

2. The acute battering incident is typically triggered by some external event or internal state of the batterer. It is an episode of acute violence distinguished by lack of control, lack of predictability, and major destructiveness. The cycle of violence can be interrupted before the acute battering incident if proper interventions take place.

3. The tranquil, loving phase is sometimes termed the honeymoon period. This phase may be characterized by extremely kind and loving behavior on the part of the batterer as he tries to make up with the woman, or it may simply be manifested as an absence of tension and violence. Without intervention this phase will end and the cycle of violence will continue. Over time the violence increases in severity and frequency.

**Characteristics of Battered Women**

Battered women often hold traditional views of sex roles. Many were raised to be submissive, passive, and dependent and to seek approval from male figures. Some battered women were exposed to violence between their parents, whereas others first experienced it from their partners. Many battered women do not work outside the home. As part of the manipulation of batterers, they are isolated from family and friends and totally dependent on their partners for their financial and emotional needs.

Women with physically abusive partners nearly always experience psychologic abuse as well and have been told repeatedly by their batterers that the family’s problems are all their fault. Many believe their batterers’ insults and accusations. As these women become more isolated, they find it harder to judge who is right. Eventually they fully believe in their inadequacy, and their low self-esteem reinforces their belief that they deserve to be beaten. Battered women often feel a pervasive sense of guilt, fear, and depression. Their sense of hopelessness and helplessness reduces their problem-solving ability. Battered women may also experience a lack of support from family, friends, and their religious community.
Characteristics of Batterers

Batterers come from all backgrounds. They often have feelings of insecurity, socioeconomic inferiority, powerlessness, and helplessness that conflict with their assumptions of male supremacy. Emotionally immature and aggressive men have a tendency to express these overwhelming feelings of inadequacy through violence. Many batterers feel undeserving of their partners, yet they blame and punish the very women they value.

Battered women often describe their husbands or partners as lacking respect toward women in general, having come from homes where they witnessed abuse of their mothers or were themselves abused as children, and having a hidden rage that erupts occasionally. Batterers accept traditional macho values, yet when they are not angry or aggressive, they appear childlike, dependent, seductive, manipulative, and in need of nurturing. They may be well respected in the community. This dual personality of batterers reflects the conflict between their belief that they must live up to their macho image and their feelings of inadequacy in the role of husband or provider. Combined with low frustration tolerance and poor impulse control, their pervasive sense of powerlessness leads them to strike out at life’s inequities by abusing women.

NURSING MANAGEMENT

Nurses often come in contact with abused women but fail to recognize them, especially if their bruises are not visible. Women at high risk for battering often have a history of alcohol or drug abuse, child abuse, or abuse in the previous or present relationship. Other possible signs of abuse include expressions of helplessness and powerlessness; low self-esteem revealed by the woman’s dress, appearance, and the way she relates to healthcare providers; signs of depression evidenced by fatigue, hopelessness, and somatic problems such as headache, insomnia, chest pain, back pain, or pelvic pain; and possible suicide attempts. In addition, the abused woman may have a history of missed or frequently changed appointments, perhaps because she had signs of abuse that kept her from coming in or because her partner prevented it.

Because female partner abuse is so prevalent, many caregivers now advocate universal screening of all female clients at every health encounter. Screening should be done privately, with only the caregiver and client present, in a safe and quiet place. Specific language leads to higher disclosure rates. Possible screening questions include the following (ACOG, 1999):

1. Has your partner or anyone close to you ever threatened to hurt you?
2. During the past year, have you been kicked, hit, choked, or hurt physically?
3. Has your partner or anyone else ever forced you to have sex?

During the screening, assure the woman that her privacy will be respected (Figure 4–11 ). It is essential to remain

DEVELOPING CULTURAL COMPETENCE

LATINA WOMEN WHO ARE VICTIMS OF ABUSE

To provide nursing care to Latina women who are victims of abuse, consider the following:

■ Culturally it is often difficult for Latina women to seek help outside their families.
■ Some Latina women who experience abuse may perceive it as their lot in life because of the concept of marianismo or the myth of martyrdom, which says that it is a woman’s duty to sacrifice all for her family, even her own health and well-being (Mattson & Rodriguez, 1999).
■ Language can be a powerful barrier to effective communication. Thus, it is important to have Spanish-speaking nurses and personnel available.
■ Similarly, assessment tools should be translated into Spanish.
■ Latina clients are often receptive to questions about how to screen other women for abuse. When asked, the woman’s desire to help another may lead her to relate her own experiences of abuse (Barcelone de Mendoza, 2001).
■ Have information available about appropriate community resources including individual and family counseling services in Spanish, shelters with bilingual staff, low-cost services, and the likes.
■ Community-run interventions designed to raise awareness and provide education can be especially effective if they are culturally sensitive and respectful of differences and individuality.

Screening for domestic violence should be done privately.
nonjudgmental. Create a warm, caring climate conducive to sharing, and demonstrate a willingness to talk about violence. A battered woman may interpret your willingness to discuss violence as permission for her to discuss it as well.

When a woman seeks care for an injury, be alert to the following cues of abuse:

- Hesitation in providing detailed information about the injury and how it occurred
- Inappropriate affect for the situation
- Delayed reporting of symptoms
- Pattern of injury consistent with abuse, including multiple injury sites involving bruises, abrasions, and contusions to the head (eyes and back of the neck), throat, chest, abdomen, or genitals
- Inappropriate explanation for the injuries
- Lack of eye contact
- Signs of increased anxiety in the presence of the possible batterer, who frequently does much of the talking

When a battered woman comes in for treatment, she needs to feel safe physically and secure in talking about her injuries and problems. If a man is with her, ask or tell him to remain in the waiting room while the woman is examined. A battered woman also needs to regain a sense of predictability by knowing what to expect and how she can interact. Provide sufficient information about what to expect in terms the woman can understand.

In providing care, let the woman work through her story, problems, and situation at her own pace. Reassure the woman that she is believed and that her feelings are reasonable and normal. Anticipate the woman’s ambivalence (due to her fear and possible love-hate relationship with her batterer), but also respect the woman’s capacity to change and grow when she is ready. The woman may need help identifying specific problems and developing realistic ideas for reducing or eliminating those problems. In all interactions, stress that no one should be abused and that the abuse is not the woman’s fault.

Nursing Care in the Community

Inform any woman suspected of being in an abusive situation of the services available in the community. A battered woman may need the following:

- Medical treatment for injuries
- Temporary shelter to provide a safe environment for her and her children
- Counseling to raise her self-esteem and help her understand the dynamics of violence
- Legal assistance for a restraining order, protection, or prosecution
- Financial assistance to obtain shelter, food, and clothing
- Job training or employment counseling
- An ongoing support group with counseling

If the woman returns to an abusive situation, encourage her to develop an exit plan for herself and her children, if any. As part of the plan, she should pack a change of clothing for herself and her children, including toiletries and an extra set of car and house keys. She should store these items away from the house with a friend or relative. If possible she should have money, identification papers (driver’s license, social security card, and birth certificates for herself and her children), checkbook, savings account information, other financial information (such as mortgage papers, automobile papers, and pay stubs), court papers or orders, and information about the children to help her enroll them in school. She should also plan where she will go, regardless of the time of day. Ensure that the woman has a planned escape route and emergency telephone numbers she can call, including local police, a phone hotline, and a women’s shelter if one is available in the community.

Working with battered women is challenging, and many healthcare providers feel frustrated and impotent when the women repeatedly return to their abusive situations. Nurses must realize that they cannot rescue battered women; battered women must decide on their own how to handle their situations. Effective nurses provide battered women with information that empowers them in decision making and supports their decisions, knowing that incremental assistance over the years may be the only alternative until the battered women are ready to explore other options.

SEXUAL ASSAULT AND RAPE

Broadly, sexual assault is involuntary sexual contact with another person. The National Crime Victimization Survey defines rape as forced sexual intercourse, including both physical force as well as psychologic coercion. Forms of forced sexual intercourse include vaginal, anal, or oral penetration by the offender(s) (Rape, Abuse, and Incest National Network [RAINN], 2003a).

Research indicates that one in six American women over age 12 has been the victim of sexual assault or rape. However, the incidence of sexual assault is down by half since 1993. In 2002 there were 247,730 reported sexual assaults and rapes, compared to 485,000 in 1993. Experts attribute this dramatic decline to two trends (RAINN, 2003b):

1. Tough-on-crime policies with longer sentences and three-strike laws. All types of criminals commit rapes, and rapists often commit other forms of crime.

2. Generational changes. Over three fourths of rape survivors are under 30 years of age and have grown
up knowing that “no means no.” These young women are more cautious about potentially risky situations and more willing to express their wishes forcefully.

Even more encouraging, in 2002 over half (53.7%) of sexual assaults and rapes were reported to the police (Rennison & Rand, 2003). This change is probably related to increased media attention and greater societal openness about the subject.

No woman of any age or ethnicity is immune. However, statistics indicate that young, unmarried women, women who are unemployed or have a low family income, and students have the highest incidence of sexual assault or attempted assault.

Why do men rape? Of the many theories put forth, none provides a completely satisfactory explanation. So few assailants are actually caught and convicted that a clear characteristic of the assailant has not been developed. However, rapists tend to be emotionally weak and insecure and may have difficulty maintaining interpersonal relationships. Many assailants also have trouble dealing with the stresses of daily life. Such men may become angry and overcome by feelings of powerlessness. They then commit a sexual assault as an expression of power or anger.

Acquaintance rape, which occurs when the assailant is someone with whom the victim has had previous nonviolent interaction, is the most common form of rape. In fact, in 69% of the cases of rape or sexual assault, the assailant is known (Rennison & Rand, 2003). One type of acquaintance rape, date rape, which occurs between a dating couple, is an increasing problem on high school and college campuses. In some cases an assailant uses alcohol or other drugs to sedate his intended victim. One drug, flunitrazepam (Rohypnol), has gained notoriety as a date rape drug because it frequently produces amnesia in its victims. In date rape situations, the male is usually determined to have sex and will do whatever he feels necessary if denied.

Responses to Sexual Assault
Sexual assault is a situational crisis. It is a traumatic event that the survivor cannot be prepared to handle because it is unforeseen. Following an assault the victim generally experiences a cluster of symptoms, described by Burgess and Holmstrom (1979) as the rape trauma syndrome, which last far beyond the rape itself. These phases are described in Table 4–3. Although the phases of response are listed individually, they often overlap, and individual responses and their duration may vary. A fourth phase—integration and recovery—has also been suggested (Holmes, 1998).

Research suggests that survivors of sexual assault may exhibit high levels of post-traumatic stress disorder, the same disorder that developed in many of the veterans of the Vietnam War. Post-traumatic stress disorder is marked by varying degrees of intensity. Assault victims with this disorder often require lengthy, intensive therapy to regain a sense of trust and feeling of personal control.

Care of the Sexual Assault Survivor
Survivors of sexual assault often enter the healthcare system by way of the emergency department. Thus, the emergency department nurse is often the first person to counsel them. Because the values, attitudes, and beliefs of the caregiver necessarily affect the competence and focus of the care, it is essential that nurses clearly understand their feelings about sexual assault and assault survivors and resolve any conflicts that may exist. In many communities a specially trained sexual assault nurse examiner (SANE) coordinates the care

<table>
<thead>
<tr>
<th>Phase</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute phase (disorganization)</td>
<td>Fear, shock, disbelief, desire for revenge, anger, anxiety, guilt, denial, embarrassment, humiliation, helplessness, dependence, self-blame, wide variety of physical reactions, lost or distorted coping mechanisms</td>
</tr>
<tr>
<td>Outward adjustment phase (denial)</td>
<td>Survivor appears outwardly composed, denying and repressing feelings (e.g., she returns to work, buys a weapon); refuses to discuss the assault; denies need for counseling</td>
</tr>
<tr>
<td>Reorganization</td>
<td>Survivor makes many life adjustments, such as moving to a new residence or changing her phone number; uses emotional distancing; may engage in risky sexual behaviors; may experience sexual Dysfunction, phobias, flashbacks, sleep disorders, nightmares, anxiety; has a strong urge to talk about or resolve feelings; may seek counseling or remain silent</td>
</tr>
<tr>
<td>Integration and recovery</td>
<td>Time of resolution; survivor begins to feel safe and be comfortable trusting others; places blame on assailant; may become an advocate for others</td>
</tr>
</tbody>
</table>
of survivors of sexual assault, gathers necessary forensic evidence, and is then available as an expert witness when assailants are tried for the crime.

The first priority in caring for a survivor of a sexual assault is to create a safe, secure milieu. Admission information is gathered in a quiet, private room. The woman should be reassured that she is safe and not alone. The nurse assesses the survivor’s appearance, demeanor, and ways of communicating for the purpose of planning care. Initially the woman is evaluated to determine the need for emergency care. Obtaining a careful, detailed history is essential. After the woman has received any necessary emergency care, a forensic chart and kit are completed.

The woman is given a thorough explanation of the procedures to be carried out and signs a consent form for the forensic examination and collection of materials. Sexual assault kits contain all the necessary supplies for collecting and labeling evidence. The woman’s clothing is collected and bagged, swabs of stains and secretions are taken, hair samples and any fingernail scrapings are collected, blood samples are drawn, tissue swabs are obtained, and photographs are taken. Vaginal and rectal examinations are performed, along with a complete physical examination for trauma. The woman is offered prophylactic treatment for sexually transmitted infections. If the assailant’s HIV status is not known, the woman may be offered postexposure prophylaxis with HIV antiviral medications. In such cases, consultation with an HIV specialist is advised (CDC, 2002). The woman is also questioned about her menstrual cycle and contraceptive practices. If she could become pregnant as a result of the rape, she is offered postcoital contraceptive therapy.

Throughout the experience the nurse acts as the sexual assault survivor’s advocate, providing support without usurping decision making. The nurse need not agree with all the survivor’s decisions but should respect and defend her right to make them.

The family members and friends on whom the survivor calls also need nursing care. The reactions of the family will depend on the values to which they ascribe. Many families or mates blame the survivor for the assault and feel angry with her for not having been more careful. They may also incorrectly view the assault as a sexual act rather than an act of violence. They may feel personally wronged and see the survivor as devalued or unclean. Their reactions may compound the survivor’s crisis. By spending some time with family members before their first interaction with the survivor, the nurse can perhaps reduce their anxiety and absorb some of their frustrations, sparing the woman further trauma.

Sexual assault counseling, provided by qualified nurses or other counselors, is a valuable tool in helping the survivor come to terms with her assault and its impact on her life. In counseling, the woman is encouraged to explore and identify her feelings and determine appropriate actions to resolve her problems and concerns. The counselor must avoid reinforcing the prevalent myth that the assault was somehow the woman’s fault. The fault lies with the assailant. The counselor also plays an important role in emphasizing that the loss of control the woman experienced during the rape was temporary and that the woman can regain a feeling of control over life.

Prosecution of the Assailant

Legally, sexual assault is considered a crime against the state, and prosecution of the assailant is a community responsibility. The survivor, however, must begin the process by reporting the assault and pressing charges against her assailant. In the past, the police and the judicial system were notoriously insensitive in dealing with survivors. However, many communities now have classes designed to help officers work effectively with sexual assault survivors or have special teams to carry out this important task.

Many women who have sought to use the judicial process have had such a traumatic experience that they refer to it as a second assault. The woman may be asked repeatedly to describe the experience in intimate detail, and her reputation and testimony may be attacked by the defense attorney. In addition, publicity may intensify her feelings of humiliation, and, if her assailant is released on bail or found not guilty, she may fear retaliation.

The nurse acting as a counselor needs to be aware of the judicial sequence to anticipate rising tension and frustration in the survivor and her support system. The woman needs consistent, effective support at this crucial time.
LEARNING OBJECTIVES

Summarize information that women may need to implement effective self-care measures for dealing with menstruation.

CONCEPTS

For effective self-care the woman may need information about:
1. Choice of sanitary protection:
   - Pads.
   - Tampons.
2. Use of vaginal sprays.
3. Douching practices.
4. Comfort measures:
   - Proper nutrition.
   - Exercise.
   - Use of heat and massage.

1. Dysmenorrhea:
   - Begins at onset of menstruation and disappears by the end of menstruation.
   - Treated with oral contraceptives, NSAIDs, or prostaglandin inhibitors.
   - Self-care measures include improved nutrition, exercise, heat application, and extra rest.

2. Premenstrual syndrome:
   - Symptoms are associated with the luteal phase (2 weeks prior to onset of menses).
   - Pronounced symptoms begin 2–3 days before onset of menstruation and subside as menstruation starts.
   - Symptoms disappear with or without treatment.
   - Treatment includes the use of progestosterone agonists and prostaglandin inhibitors.
   - Self-care measures include use of vitamin B and E supplements, calcium, avoidance of sodium and caffeine, and increased aerobic exercise.

1. Fertility awareness methods:
   - Advantages: Natural and noninvasive.
   - Disadvantages: Requires extensive initial counseling for effectiveness. Requires couple to practice abstinence during parts of each month.
   - Effectiveness: In practice, it may be less reliable than other methods.

2. Barrier contraceptives:
   - Advantages: Easy to use with no side effects. Condoms prevent spread of most venereal diseases.
   - Disadvantages: Some types must be fitted by a nurse practitioner or physician. Must be placed prior to intercourse. Must be used with spermicides.
   - Effectiveness: Excellent when used correctly.

3. Spermicides:
   - Advantages: Inexpensive and easy to obtain.
   - Disadvantages: Must be applied prior to intercourse. Considered “messy” by many people.
   - Effectiveness: Minimally effective when used alone.

4. Intrauterine devices:
   - Advantages: Effective for up to 5 years (Mirena) or 10 years (ParaGard) without removal.
   - Disadvantages: May cause cramping and bleeding for first 3–6 months. Woman must check for proper placement after each menses. Does not protect from STIs. May predispose woman to PID.
   - Effectiveness: Very effective while in place.

5. Hormonal contraceptives:
   - Advantages: Menstrual symptoms are lessened. Menstruation is very predictable.
   - Disadvantages: May increase chance of blood clots. Should not be used by anyone who smokes, has a heart condition, or has previous history of thromboembolic disease. Does not protect from STIs.
   - Effectiveness: Highly effective when used correctly.

6. Sterilization:
   - Advantages: Permanent form of birth control. No additional costs once procedure is completed.
   - Disadvantages: Considered nonreversible. Requires general anesthesia for the woman and local anesthesia for the man. Vasectomy does not produce immediate sterility; semen sample must be clear before other form of contraception is stopped. Does not protect against STIs.
   - Effectiveness: Considered completely effective.

(continued)
**LEARNING OBJECTIVES**

Delineate basic gynecologic screening procedures indicated for well women.

Discuss the physical and psychologic aspects of menopause.

Explain the cycle of violence and its application to battered women, including pregnant women.

Delineate the nurse’s role in working with women who have experienced intimate partner violence or rape.

**CONCEPTS**

2. Mammography: Recommended every 1–2 years after age 40 and annually for women age 50 or older.

1. Physical aspects of menopause:
   - Ovulation ceases 1–2 years prior to menopause.
   - Gradual atrophy of ovaries.
   - FSH levels rise.
   - Less estrogen is produced.
   - Atrophic changes of vagina, vulva, urethra, and bladder.
   - Vasomotor disturbances such as “hot flashes.”
   - Atrophy of uterine endometrium and myometrium, and fallopian tubes.
   - Constriction of uterine cavity.
   - Vaginal tissue becomes smooth, thins, and loses elasticity.
   - Thinning of pubic hair.
   - Decreased pelvic support.
   - Decrease in breast firmness.
   - Possible development of osteoporosis.
   - Increased risk of coronary heart disease.

2. Psychologic aspects of menopause:
   - Possible helpless feelings at physical changes.
   - Fatigue from lack of sleep due to hot flashes.
   - Decreased libido.
   - Possible increase in enjoyment of sexual intercourse due to lack of worry about pregnancy.

Cycle of violence:
1. Tension-building phase:
   - Batterer demonstrates power and control.
2. Acute battering incident:
   - Triggered by an external event or internal state of batterer.
   - Episode of acute violence.
3. Tranquil phase:
   - Kind and loving behavior on part of batterer as way to make up for violence.

Application to battered women:
1. Woman may have been raised to be submissive, passive, and dependent.
2. Develop a sense of hopelessness.
3. Incidents may increase during pregnancy.

The nurse’s role includes the following:
1. Create a safe, secure milieu.
2. Obtain a careful, detailed history.
3. Complete a forensic chart and kit.
4. Explain all procedures.
5. Act as the survivor’s advocate.

**CRITICAL THINKING IN ACTION**

View the Critical Thinking in Action video in Chapter 4 of the CD-ROM. Then, answer the questions that follow.

You are working at a local clinic when Joy Lang, age 20, presents for her first pelvic exam. You obtain the following GYN history: menarche age 12, menstrual cycle 28–30 days lasting 4–5 days, heavy one day, then lighter. She tells you that she needs to use superabsorbent tampons on the first day of her period and then she switches to a regular absorbency tampon for the remaining days. She confirms that she changes the tampon every 6 to 8 hours, never leaving it in overnight. She denies premenstrual syndrome, dysmenorrhea, or medical problems and says that she is not taking any medication on a regular schedule. She tells you that she recently got married, but would like to wait before getting pregnant. She’d like to discuss birth control methods. Joy tells you that doctors...
make her nervous and she admits to being anxious about her first pelvic exam.
1. What steps would you take to reduce Joy’s anxiety relating to the pelvic exam?
2. What position is best to relax Anita’s abdominal muscles for the pelvic exam?
3. What precaution should be taken when obtaining a Pap smear?
4. Explain the purpose of the Pap smear.
5. What factors do you include in a discussion of the type of birth control that Joy could practice?

MediaLink

- NCLEX-RN® Review, case studies, and other interactive resources for this chapter can be found on the Companion Website at http://www.prenhall.com/london. Click on “Chapter 4” to select the activities for this chapter.

- For animations, more NCLEX-RN® Review questions, and an audio glossary, access the accompanying CD-ROM in this textbook.

References