Couples Counseling at an Abortion Clinic: A Pilot Study

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ABSTRACT

Approximately half of all pregnancies in the U.S. are unintended. Non-use, incorrect, or inconsistent use of contraception may be related to limited support of male partners. Partners often accompany women having abortions, representing an opportunity for health providers to engage them. This pilot study estimates the proportion of abortion patients accompanied by a male partner and the proportion agreeing to couples counseling and describes couples' experiences with it. At a Baltimore clinic, after preliminary qualitative research, we recorded the number of patients who came with partners and accepted couples counseling in a three-month period, and sought feedback on the counseling in 66 questionnaires from women, partners and the counselor. Overall, 27% of patients came with their male partner. Among all couples, 42% accepted couples counseling. Aspects of counseling that patients appreciated were having the partner's support, having an informed partner with whom to communicate, and being able to share decision-making.

About half of all pregnancies in the U.S. are estimated to be unintended from national survey data. While unintended pregnancy rates have declined for some Americans, such as college graduates and wealthier women, the rate of unintended pregnancy is higher than average for unmarried and lower-income women, women without high school diplomas, and minority women.[1] About half of unintended pregnancies end in abortion.

Historically, unintended pregnancy has been defined and treated as a problem of women. However, conception involves two persons. To underscore this, for intended pregnancies, one sometimes hears partners announcing A*we* are pregnant.@ Furthermore, recent studies have shown the importance of the male partner in the woman=s decision about carrying (or not) the pregnancy to term.[2]

There are over a million abortions performed annually in the United States.[3] Nearly half of women undergoing abortion in recent years did not have any contraceptive protection during the month that they became pregnant; many women and couples who were using contraception, were using it inconsistently. Furthermore, about half of abortions in the U.S. are repeat abortions[4] so there is a lack of effective contraceptive use even after an abortion for thousands of women and couples.

The contraceptive non-use and misuse that often lead to an unintended pregnancy may indicate a lack of male partner involvement in contraceptive decision-making. Several experimental studies have shown that involving male partners in contraception through education and/or counseling leads to greater contraceptive acceptance and continuation within couples. In a study in the Northwest U.S., Danielson et al[5] found that male adolescents (n=1200) randomly assigned to participate in contraceptive education and counseling were significantly more likely than a control group to report at a follow-up visit that last sex was protected by pill use. In Ethiopia, a randomized field trial of family planning education with home visitation among 527

married couples found that husband=s participation was positively associated with use of contraception at 2- and 12-month follow-ups.[6] In China, a randomized trial (n=1800) of family planning education targeting both spouses compared to wife-only education found that husband=s involvement led to lower pregnancy and abortion rates among non-IUD using women.[7]

Thus, male involvement in contraceptive counseling at the time of abortion could lead to increased use of effective contraception following an abortion. In this regard, from a national sample of 46 abortion clinics, Henshaw and Kost[8] reported that 37% of adolescents aged 15-17 seeking abortion came to the clinic with a boyfriend. More recently, a study at a hospital abortion clinic in Baltimore found that 30% of women came with and 34% left with a male partner.[9] Internationally, male partners accompanying women receiving post-abortion care in a hospital in Tanzania were willing to participate in contraceptive counseling.[10] Furthermore, an experimental study of counseling of husbands of women receiving post-abortion care in upper Egypt[11] showed a significant effect of the counseling on contraceptive use of the couple one month post-partum in three small hospitals, though interestingly not in three large hospitals.

Male partners can play a significant role in the decision-making and support surrounding pregnancy termination by providing emotional support and financial assistance.[12,13,14] Partners may also play a role in decision-making with regard to post-abortion contraceptive choicesBthis is certainly the case if condom is the choice. Abortion providers can make the most of the opportunity of having both partners present to encourage inter-partner communication about future contraceptive use.

The present research was designed to answer three questions:

1. What proportion of women seeking an abortion at a Baltimore clinic comes with their male partner, among African-Americans, Whites and Hispanics/Others?

2. What proportion of women coming to the clinic with their partners actually agrees to and has couples counseling?

3. What are the opinions of the women and men who had couples counseling, and the counselor, on their experience?

METHODS

This pilot study was carried out at the Planned Parenthood of Maryland (PPM) clinic in Baltimore, Maryland. Usual clinic procedures are as follows: Prior to all abortion procedures, patients undergo laboratory testing, ultrasound gestational age dating, and informed consent for the abortion procedure. Additional information is routinely provided regarding all available methods of birth control, use of condoms for prevention of sexually transmitted infections, and availability and use of emergency contraception. Patients are encouraged to begin a method of contraception immediately after the abortion procedure. Referrals are available for services not provided at PPM. All patients are interviewed privately at some point during their visit, but may be accompanied by an individual of their choice during the informed consent/counseling session, if they so choose.

This study consisted of two phases. In the first phase, qualitative data were collected to determine the feasibility and best format for couples counseling. In the second phase, couple counseling was offered to women; patients were specifically asked if their partner was with them in the clinic, and if they wanted the partner to be part of the counseling. Tallies were kept of women who came with partners and couples who accepted couples counseling. Feedback on the sessions was collected through questionnaires. Table 1 outlines the study components and details

are given below. Minors were excluded from the questionnaires but were included in the daily counts of clinic patients. Prior to initiation, the Committee on Human Subjects of the Johns Hopkins School of Public Health as well as the National office of Planned Parenthood Federation of America approved this study.

TABLE 1 ABOUT HERE

Data Collection

Using a short self-administered questionnaire, data in phase I were collected between September and December 2005 from a sample of patients and partners in the clinic waiting room. To gain a wide range of perspectives, we sampled participants in three strata: a) women who came to the clinic alone; b) women who came to the clinic with a partner; and c) male partners of other women (not of women sampled in group b). The questionnaires were administered on different days of the week and different times of day. A sample size of 20 in each stratum was deemed sufficient to examine major themes. Respondents received $5 each for returning the questionnaire.

In the questionnaire, women were asked whether they would prefer counseling alone, with their partner, or whether they had no preference. Regarding couples counseling, the questionnaire asked women what topics should be covered, what should be emphasized to prevent future unwanted pregnancies and what problems may arise. They were also asked how the clinic could be made more appealing to both women and men. The male partner=s questionnaire asked whether he would or would not want to attend contraceptive counseling or abortion counseling with his partner, as well as some of the same questions posed to women.

In phase II of the study, couples counseling was offered to women who came to the abortion clinic accompanied by a partner. The counselor asked each patient if she was

accompanied by her partner and if she was, the counselor asked her whether she would like to have the partner with her in the counseling session. Women could voluntarily accept couples counseling or decline and have individual counseling. If the woman accepted couples counseling, the partner could voluntarily accept or decline.

By "counseling", in this paper we are referring to a 15 to 20-minute session which was mainly educational. In this session, a counselor/educator discussed with the patient (and partner, if present) specific information related to the abortion procedure options, post-abortion contraceptive preferences, and any other topics that the patient and/or partner wanted to discuss. A recommendation of condom use for prevention of sexually transmitted infections was also part of the session. The counselor generally asked the partner if he had any questions. For surgical abortion procedures, she asked if the partner would be driving home and for medical abortion patients, if he would be with the patient on the day that she would take misoprostol. The counseling session also involved patient=s signing of administrative and informed consent forms for the abortion procedure.

A tally of all patients was carried out from May 2 to July 19, 2006. For each woman who presented for abortion, the counselor recorded whether the woman came to the clinic alone, with someone other than her partner, or with her partner. For those who came with partners, the counselor also recorded whether she and her partner accepted and participated in couples counseling or whether the woman or man declined to participate. This tallying was done by race/ethnicity, and ended after 100 African-American women came with their partners. This sample size was selected in order to achieve a precision of + or - 10%, with 95% confidence, for the proportion of African-American women with partners who accepted couples counselingCAfrican-Americans are the majority racial/ethnic group in the Baltimore clinic*.

In June 2006, after the recording procedures described above were in place, all couples receiving counseling were asked if they would agree to complete a short self-administered questionnaire; this was done until 20-25 women and their partners completed questionnaires. Informed consent was obtained and the woman and her partner each received $5 for completed questionnaires. The questionnaire asked about race/ethnicity, marital status, education, previous abortions, use of contraception (or not) at the time of conception (for women), and whether the woman and her partner expected the partner to be involved or not. If the answer was yes, the woman and her partner were asked in which aspects (abortion counseling, contraceptive counseling, being with the patient during the procedure, or other) she or he expected him to be involved. Also, in open-ended questions, the woman and her partner were asked what they learned in the couples' session that they did not know before, whether there were things that they wished the counselor had discussed with them, and suggestions for including partners in the abortion process. Additionally, women were asked what they liked and did not like about having their partner included, and how satisfied they were with the couples counseling.

The counselor also completed a questionnaire about the session to report her perception of the interactions in the session. The counselor was asked how interested she felt the woman and partner were (on a scale of 1 to 10); how sure she felt the woman was to have her partner involved, and how sure she felt the partner wanted to be involved; who asked more questions and interrupted more; relevant issues raised by the partner and whether there was anything problematic in the session. An open-ended item asked the counselor what questions she asked of the partner, and about her comments on the session.

Data Entry and Analysis

Data from the tally were double-entered in Excel. Proportions were calculated in Excel and confidence intervals and p-values in Stata 8.0.[15] The age of patients during the tally period was obtained from clinic records. For both phase I and II questionnaires, data were double-entered into EpiInfo 3.3.2[16] and transferred to Stata for analysis. The phase II datasets were merged (women, partners, and counselor) based on common identification number of the counseling session and then cross-tabular analyses were done. Qualitative responses were entered in word processing software, and coded thematically.

RESULTS

Phase I Quantitative

Completed questionnaires for the three groups--women alone, women with partners, and male partners numbered 19, 16, and 23, respectively, for a total of 58 respondents. Women in both groups responding to the questionnaire were 71% African-American, 23% White and 6% Hispanic/Other. Women aged 18-19 comprised 11% of the respondents, 60% were aged 20-29 and 29% were age 30 or older. Half of the sample was using contraception at the time of the pregnancy and for 54%, this was not the first abortion. Male partners were 56% African-American, 35% White, and 9% Hispanic/Other. Males were older, with 70% aged 20-29, and 17% were age 30 or older. Approximately two-thirds of women and male partners each had some college education.

When asked about their preference for couples counseling, 46% (n=13) of the women reported no specific preference, 17% (n=6) preferred counseling with their partner present, and 37% (n=46) preferred to have counseling alone**. In the questionnaire, male partners were asked, "If you could attend one of the following, which would it be?" and the response categories offered were a) abortion counseling, b) contraceptive counseling, c) would not want to be present, or d) other. A third (32%, n=7) chose the abortion counseling, 18% (n=4) the contraceptive counseling, 9% (n=2) chose another topic, and 41% (n=9) did not want to attend. Overall, 63% (22/35) of women and 59% (13/22) of men were open to having couples counseling.

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Phase I Qualitative Results: *Women*

Responses to the open-ended questions were generally brief. In answer to a question about what should be covered in couples counseling on contraception, many women mentioned method effectiveness. Some women wanted the fact to be emphasized that contraception Ais not 100%@ [effective] and that counseling should cover simply Athat you should use contraception.@ Other women wanted information on the pill or condoms, Amedically-inserted devices@, sterilization, side effects and the Apros and cons of all the methods.@ Some women also emphasized consistency of use (AOnce picking a form of contraception, sticking with it each time you have sex, not just occasionally.@).

Responses to the question on what should be covered in the counseling often underscored a shared responsibility with the partner for contraception or condom use. One woman raised the issue of the Acouples= commitment to the acts of pregnancy prevention and to each other@ and another woman wanted to find out Awhat the male can do to contribute.@ Another woman affirmed, AIt=s as much his responsibility as hers.@ Several women wanted discussion of safe sex in counseling, and the fact Athat it=s ok to wear a condom even with your partner.@ Partner agreement related to contraceptive use was an issue for some women (AMen should be equally willing to use contraception as females.@). A couple not agreeing to use contraception would Aput the other person in a difficult situation,@ wrote one woman. Several respondents wanted to learn about Acontraception for both partners@ and mentioned that Aboth parties should know the pros and cons of all contraceptives.@ One woman wanted the couples counseling to cover Ahow the guy feels about it.@

Among the potential problems that could arise in couples counseling, some women who came to the clinic alone discussed a potential lack of interest (AOne partner would take it more seriously than the other.@; AThe male may not want to participate.@). One woman questioned

why her partner should attend couples counseling (AI don=t think my ex would understand why he should be there if I am the one to take [contraception].@) and another did not want her partner involved at all. Women who came with their partners raised the possibility that the partner may feel uncomfortable and that an argument could arise if the partner did not agree to the Aprocedure,@ probably referring to the abortion. Several women emphasized the need to make sure that the woman agrees to have the male in couples= counseling.

Partners

When asked what should be covered in couples counseling, several men wanted more information on the abortion services (AI=m not exactly sure what the process is to have an abortion so I would just like to know a little bit more.@; AI have never been through the abortion process. I am unfamiliar with the how and what.@). Others referred to emotional issues or support (Ato work through the various emotional aspects@; Ahelp to deal with past situations@).

Regarding couples counseling, some men wanted information on contraceptive effectiveness and referred to an information need of their female partner (AMy mate needs to be informed about the proper use of condoms.@; AMy partner needs to know the importance of protection.@). Some men wrote about a shared responsibility for contraception (ASince the situation we find ourselves in is a 50/50 deal, I want to be part of every step.@). On the other hand, several men indicated that they would not want to be present at counseling with their partner. Some considered themselves already knowledgeable and said that the counseling would be redundant (AMy partner and I are pretty level-headed, we can figure most things out on our own.@)

According to responses from both women and male partners, three themes emerged on how the clinic could be made more appealing or friendly to both sexes. First, half of men requested a TV and/or magazines,. Second, several men requested to be with the woman during

the abortion process. Third, several women mentioned aspects of the clinic experience that could be modified including waiting room decor. There were also many patients who were satisfied with the clinic just as it is.

Phase II Tally Results

In the tally phase, all patients presenting at the clinic were counted according to several characteristics. Among 774 abortion patients in the time period covered by this phase of the study (May 2 to July 19, 2006), 62% were African American, 30% White and 8% Hispanic/Other. A quarter (24%) of patients were adolescents, 38% were age 20-24, 18% were age 25-29, and 20% were 30 years old or older, according to the clinic records.

Overall, 27% of all women came with their male partner (*95% CI: 24-31%*), 45% came alone (*95% CI: 41-48%)* and 28% (*95% CI: 25%-31%)* came with someone who was not a sexual partner, such as a friend or relative. There were significant differences by race/ethnicity ($p<.001$) (Figure 1). African Americans were more likely than Whites to come alone (48% vs. 35%) and less likely than Whites to come with their partner (23% vs. 35%). Among Hispanics and women of other ethnicities (n=60), 35% came with a partner, half came alone (52%), and 13% came with someone else.

FIGURE 1 ABOUT HERE

Among all women who came with partners, 42% accepted and had couples counseling (data not shown). Acceptance was lower among African-Americans (38%) than among whites (43%). The highest acceptance was among Hispanics/Other women (58%). However, these differences were not statistically significant. Among all couples, only 3% of males declined couples counseling if the woman had already agreed to it.

Phase II Questionnaire Results

Twenty-two of 43 couples who received counseling together and were asked if they wanted to complete a questionnaire did so, giving a response rate of 51%. A comparison of those who did and did not participate in the survey showed no significant differences by racial/ethnic group (not shown).

Among the 22 women in the couples who completed the questionnaires, half were African-American, 7 were white and 4 Hispanic. Thus, the survey participants were less likely to be African-American than all patients. Among male partners, 14 were African-American, 7 were white, and 1 was Hispanic. Over half of women and half of men had some college education. Among women, 8 reported that they had used contraception at the time of pregnancy and 6 had had an abortion before.

Most of the women (17) and their partners (13) who completed the survey had expected the partner to be involved (Figure 2). Over half of the women expected that their partner would be part of the abortion counseling, 5 expected their partner to be with them for the procedure, and 4 expected their partner to be involved in contraceptive counseling. Among males, 7 expected to be part of the abortion counseling, 7 expected to be present during the abortion procedure, and 5 expected to be part of the contraceptive counseling. Five women and 8 men said that they learned two or three new things in the counseling. Women were highly satisfied with the couples counseling (19 very satisfied and 1 somewhat satisfied).

FIGURE 2 ABOUT HERE

The counselor was very sure that the woman wanted her partner to be involved in the couples counseling in 64% of the sessions (Table 2). There was more variation in the counselor=s

assessment of how sure she felt the partner was that he wanted to participate (23% very sure, 36% somewhat sure and 41% somewhat unsure). According to the counselor, the woman asked more questions than her partner in 64% of the sessions. The woman interrupted more than her partner did in half (57%) of the sessions; the man interrupted more in only 24% (in the remainder, interruptions were about equal between the two partners). In nearly all sessions, the counselor asked the partner one or more questions. The partner expressed concerns in 45% of sessions and raised relevant issues in 36% of sessions, according to the counselor. The counselor=s ranking of the woman=s level of interest was on average 7.2 (on a scale from 1 to 10 with 10 meaning highly interested). The partner=s average level of interest on the same scale was 5.7, according to the counselor.

Phase II Qualitative Results*: Women*

Nearly all women (19/22) responded to the question regarding what they liked about having their partner included in the couples counseling session. Their responses indicate that the counseling was a positive experience. In contrast, all women skipped the two open-ended questions, AWas there anything else that you wish the counselor had discussed with you?@ and AWas there anything that you disliked about the session?@. What women liked about couples counseling is summarized in three themes: a) support from the partner, b) having a partner who is informed and with whom she can communicate, and c) being able to share the decision-making related to abortion.

Many women stated that the Aemotional support@ and the Acomfort@ of having their partners with them were important, and they did not want to be alone. The women wrote, AI just liked having the support of him being here with me.@; AIt was reassuring to have him there.@;

and AHe gave me support and talked me through it.@

Seven women were happy in the couples counseling to have an Aopen discussion@ and Acommunicate our feelings@, receive feedback from partners, and hear the partners= questions and thoughts. One woman Agot to hear how he really feels about the procedure,@ suggesting that she did not know how he felt before. Some patients believed that the counselor should ask how the partners are feeling and wanted the couples counseling to be routine. Three women were glad that their partner learned what they would be experiencing related to the abortion (AHe can see what a female has to go through.@; AHe got to hear all side effects so that he will be aware of anything I may go through.@)

Some women focused more on the shared aspect of the counseling. One woman affirmed, AI felt like it was our decision,@ (her emphasis). Some women wanted their partners to be with them in the recovery room, with one adding Amost women don=t want to be alone.@

Partners

When asked what two or three things they learned in the counseling that they did not already know, several men said they learned something about the abortion procedure. They wrote, Amedicine option instead of surgery,@ Athe discomfort up to six weeks after,@ Ayou can take a pill,@ Aside effects,@ and Apros and cons@ of the abortion methods. One man mentioned the Amorning after pill.@ Regarding other suggestions that male partners had about the clinic visit, one partner wrote: AEncourage [partners] to be a part of it, the process, to find out exactly what is going on.@ Another suggested that partners should Aknow from the beginning that they can be included.@

Counselor

The counselor asked partners how they were feeling and if they were comfortable. In one couple, the patient indicated to the counselor beforehand that she and her partner disagreed on having the abortion, but in the couples= session, he seemed supportive of her decision to have the procedure.

Two survey questions asked the counselor about Aproblematic interactions@ and Adiscomfort.@ There was no problematic interaction in 20 of the 22 couples= counseling sessions. In one session, the counselor explained that the partner was disinterested and was playing with his cell phone. Nevertheless, the woman indicated in her questionnaire, "It feels good that he was not left out." In the other session, the counselor explained that the patient and partner disagreed over what type of procedure she should have. After receiving more information from the counselor about the two procedures, the patient changed her mind regarding which procedure to have.

In some cases the partners raised a number of relevant matters about abortion that may not have been brought up otherwise, according to the counselor. Several men wanted to know how long it would take, what happens if the medication fails, the failure rate, when the clinic would be open for a follow-up appointment, the risks of the procedure, bleeding after the procedure, and when women could return to work. Three men asked questions about contraception and future fertility.

DISCUSSION

This study and previous studies have found that a sizable minority of women presenting for abortion in the U.S. are accompanied by their male partners. In general it is not known to what extent male partners are incorporated in abortion services. When presented with the option of having the partner involved in the counseling, over 40% of such women in this study chose that

option. Even though most contraceptive methods are for women, studies have shown that supportive male partners lead to higher use and continuation rates. The question this study addressed is to what extent partners are available and, with the woman's approval, willing to participate in contraceptive counseling at the time of abortion. Such an intervention could have potential to reduce the repeat abortion rate.

In this study, a quarter of abortion patients (27%) came to the Baltimore clinic with their partner, and this occurred in the absence of prior communication to patients that they could bring their partner and have couples counseling. The percentage of women accompanied by their partner was lower than the 37% found in the national study of adolescents seeking abortion[8] and slightly lower than the 30% of women who came to the clinic with a partner and 34% who left with a partner in a study in a Baltimore hospital abortion clinic.[9] In the present study, African-American women were less likely than Whites to come with their partner (23% vs. 35%) but the percentages who accepted couples counseling were not significantly different between the two groups. The differences between the studies in levels of male partner=s accompaniment to the abortion clinic may be due to sample sizes, the nature and location of the clinical setting, the race/ethnicity of the patient population, or type of abortion that women underwent. Currently, a minority of women actually receives couples counseling with their partner at the time of abortion in the Baltimore clinic; however, this could possibly change with increased awareness on the part of patients and partners about the availability of couples counseling.

Three-quarters of the women and two-thirds of partners who completed surveys after the counseling had expected the partner to be involved in some aspects of the visit to the abortion clinic. A substantial proportion of women and partners expected the partners to be present during the procedure, which is not currently allowed. On the other hand, even among couples in which both partners agreed to counseling, the counselor was somewhat unsure if the partner really

wanted to participate in 41% of sessions. This may reflect some awkwardness in the couple counseling session, a session which has traditionally been a patient-counselor interaction. The concern that men may dominate the couples counseling sessions was not substantiated. Women asked more questions and interrupted more than their partners did. The partner had concerns and also raised relevant issues in 36% of sessions, according to the counselor.

The qualitative data reveal that the couples counseling was largely a positive experience for both partners. Nearly all women liked something about the couples counseling, mostly the feeling of having support, not being alone, and having her partner informed of what she is going through. The sessions generally were unproblematic. Some partners believed that they should be notified in advance that they could be involved in the counseling. Some partners wanted to be with the patient during the whole process, not just counseling and this was echoed by a third of the women. A previous study in Baltimore[16] also found that women whose male partners were involved in the abortion decision prior to their arrival at the clinic generally reported the partners= involvement as positive, including discussion about the abortion decision and emotional support.

Though this was a small pilot study, nevertheless several recommendations can be stated. First, for clinics that offer couple counseling, staff can communicate with patients when they are making appointments about their ability to bring their male partners and have couples counseling. This would likely increase the proportion of women coming with their partners, and who have couples counseling. It may be important to evaluate to what extent extra time is needed for couples counseling. Second, abortion clinics that are interested in accommodating male partners may also consider the advantages and disadvantages of having the partner present in the procedure and/or recovery room, for women and partners who both want that. Voluntary involvement of partners at the time of abortion might be considered appropriate just as partner

involvement in childbirth classes and at the time of delivery is increasingly accepted and practiced in the U.S.

Including partners in counseling on contraception, abortion, and perhaps other sexual and reproductive health topics may have potential benefits for health behaviors and outcomes, and warrants further study. A prospective, randomized controlled trial is needed to determine if women and couples who have couples contraceptive counseling are more likely to be using effective contraception at a given time-point following an abortion and are less likely to have repeat abortions than a randomized control group of women who do not have couples counseling.

FOOTNOTES

***** The tallying was done every day that abortion services were offered except on six days when the usual counselor was not present.

****** By design, nearly half of the female respondents to the questionnaire had come with their partnersBhigher than the corresponding percentage in the clinic population.

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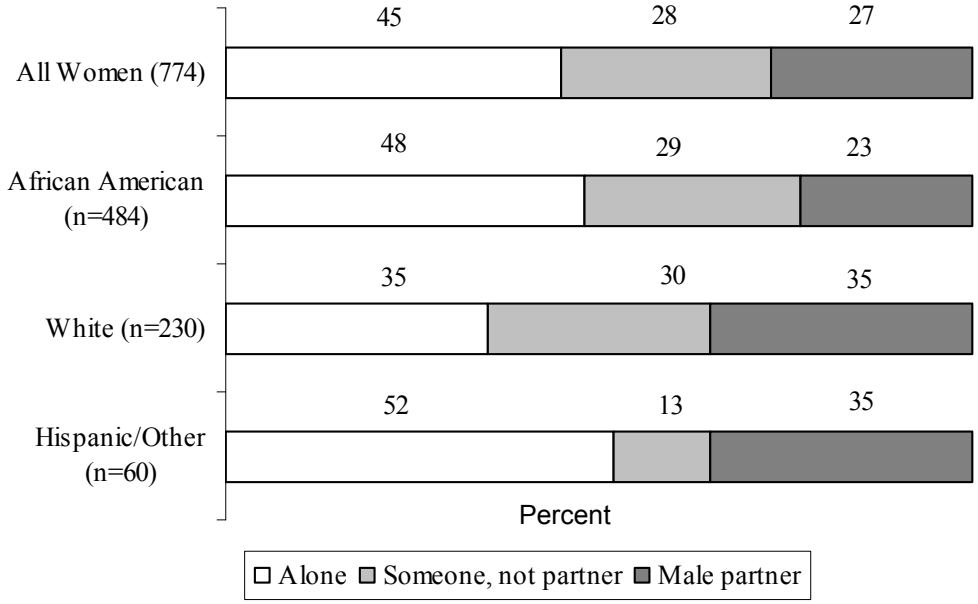
Tables and Figures

Table 1: Components of the couple counseling study at Planned Parenthood abortion clinic in Baltimore

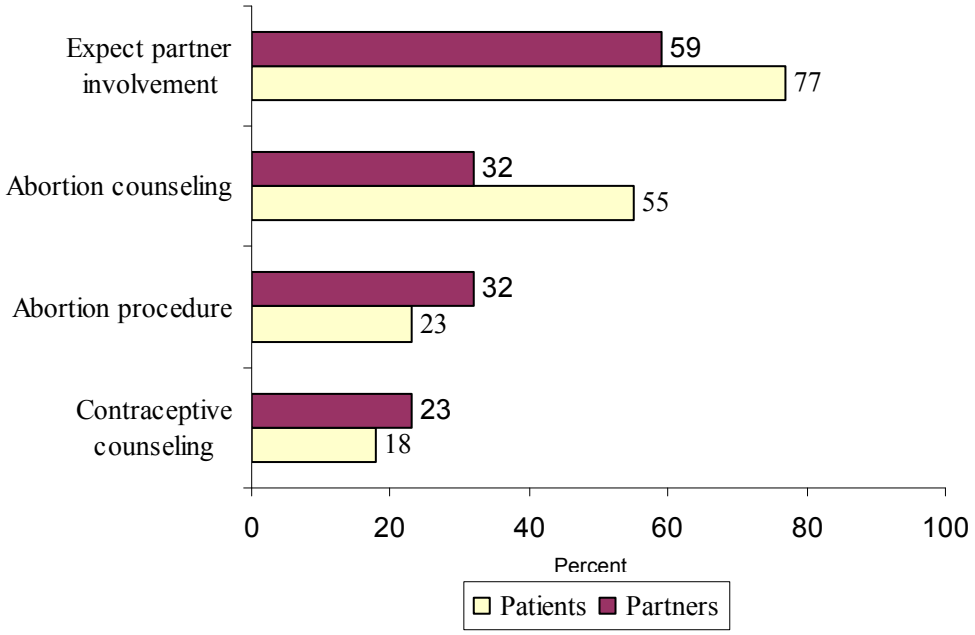
Phase I: Pre-intervention		**Desired Sample size**
	Questionnaires in the waiting room from:	
	Women who came alone	20
	Women who came with a partner	20
	Men who had come with a partner	20
Phase II: Couples counseling		
	Recording of:	
	Who accompanied women to the clinic	all women attending
	For those who came with partners, who accepts couple counseling	all women with accompanying partners
	Among those who had couples counseling	
	Questionnaires from:	
	The woman	20-25
	The partner	20-25
	The counselor	20-25

Figure 1. Percent distribution of who accompanied women to the abortion clinic, by Race/ethnicity (n=774 patients)



p-value<.001

Figure 2. Percentage of women and men who expected partner to be involved in the clinic visit, by aspect (n=22 couples)



Note: Sum of percentages may exceed 100% since respondents could choose more than one aspect of the clinic visit

Table 2. Reports on the couples counseling by the counselor (percentages) (n=22 couples)

Aspect of Couples Counseling	Patients	Male Partners
Certainty of patient wanting partner involved in counseling; certainty of partner wanting to be involved		
Very sure	64	23
Sure	23	36
Somewhat unsure	13	41
Who asked more questions?[a]	64	23
Who interrupted more?[b]	57	24
Partner raised relevant issues in counseling	--	36
Mean Interest level of the patient and partner, on a subjective scale from 1 to 10	7.2	5.7

[a] The patient and partner asked questions equally in 13% of sessions.
[b] The patient and partner interrupted equally or there were no interruptions in 19% of sessions.