Original Report

Factors Influencing Adolescent and Young Adults' First Pelvic Examination Experiences: A Qualitative Study

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A B S T R A C T

Study Objective: To understand the factors that influence individuals' experiences during their first pelvic examination.
Design, Setting, Participants, Interventions, and Main Outcome Measures: We conducted semistructured interviews with adolescents and young adults, aged 18-24, who had received at least 1 pelvic examination. Interviews explored contextual factors of the first pelvic examination, including visit acuity and clinical setting and individuals' experiences with the pelvic examination itself and elicited recommendations on how to improve the examination experience. Interviews were transcribed and computer-assisted content analysis was performed; salient themes are presented.
Results: Thirty participants completed interviews. Nineteen participants described their first pelvic examination experience as positive; 11 described this examination as a negative or neutral experience. Factors influencing the experience include the examination indication and acuity, examination location and physical space, provider features, relational and interpersonal features, and procedural aspects. Recommendations included: (1) establish rapport and educate before the examination; (2) establish practices to orient patients; (3) make no assumptions about identity; and (4) elicit continuous feedback.
Conclusion: Individuals' first pelvic examination experiences are influenced by a variety of factors. Although some factors are directly modifiable by providers, other factors that might not be modifiable are important to elicit to optimize the examination experience. These findings call for best practice guidelines and educational interventions to prepare providers to perform the first pelvic examination.
Key Words: Adolescents, Young adults, Pelvic examination, Patient–provider communication

Introduction

The circumstances under which adolescent and young adults experience their first pelvic examination are variable. Current professional guidelines from the American College of Obstetricians and Gynecologists (ACOG) recommend that individuals obtain their first pelvic examination by age 21 years, at which time they should obtain cervical cancer screening, regardless of sexual activity.[1] ACOG also recommends that adolescents have their first visit with an obstetrician-gynecologist between 13 and 15 years of age.[1,2] This first visit focuses on establishing the patient–provider relationship and educating patients. Before age 21 years, ACOG recommends that patients only obtain a pelvic examination when medically indicated.[1,2]

How adolescents and young adults experience their first pelvic examination under current practice is understudied. Although literature exists that explores individuals' experiences with the pelvic examination in general, few studies focus specifically on experiences with the first pelvic examination.[3–8] Furthermore, much of the existing literature was conducted in Europe over a decade ago[3–8] and might not be generalizable to adolescent and young adults currently receiving gynecologic care in the United States. Understanding how to optimize patients' experiences with this examination is essential. Although positive experiences have the potential to empower and educate, negative experiences might deter adolescents and young adults from seeking subsequent reproductive health care. Therefore, we conducted a qualitative study to explore adolescent and young adults' experiences during the first pelvic examination and elicit recommendations on how to improve this experience.

Materials and Methods

The data presented in this report are a subanalysis of a qualitative study exploring individuals' first pelvic examination experiences. In this article, we discuss factors influencing adolescent and young adults' experiences during the first pelvic examination. Between August 2016 and May 2017, we recruited participants from the University of Chicago campus and surrounding communities to participate in a semistructured, in-depth interview. Recruitment included social media postings, e-mails to student organizations, and flyers inviting potential participants to contact the study team via e-mail or phone. A study team member screened for eligibility and sampling criteria. Inclusion criteria included: age between 18 and 24 years and having had a pelvic examination, and ability to consent in English.

The authors indicate no conflicts of interest.
Study findings were presented, in part, at the North American Society for Pediatric and Adolescent Gynecology Annual Meeting, West Palm Beach, Florida, April 12-14, 2018.
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We used purposive sampling to invite eligible individuals to participate according to: age, race/ethnicity, education, and gynecologic history. Recruitment continued until achieving thematic saturation—the point at which no new information was gained from further data collection.[9] We obtained oral consent before conducting study procedures. Participants received $25 for participation. The University of Chicago Institutional Review Board approved study procedures.

Interviews were conducted in person, following an interview guide. Interviews were digitally recorded, transcribed, and verified. Both authors independently reviewed all interviews. We used tenants of grounded theory to develop an initial code directory that was subsequently refined through multiple readings of interviews.[9] We verbally reconciled codes with an inter-rater reliability κ score of 0.7 or less to arrive at our final code directory.[10] We used this final directory to code interviews using ATLAS.ti (version 7.8.15, Berlin, Germany). The authors met to discuss key findings, resolve disagreements regarding data analysis and interpretation, and identify major themes. In this report we present salient themes regarding factors influencing experiences during the first pelvic examination and recommendations on how to improve the examination experience (Fig. 1).

Table 1
Participant Demographic Characteristics (N = 130 Interview Participants)

Characteristic	Value
Median age of participants (range), years	22 (18-24)
Median age at first pelvic exam (range), years	19 (16-24)
Highest education level	
High school	1 (3)
Some college	10 (33)
College	10 (33)
Some graduate school	8 (27)
Graduate school	1 (3)
Race/ethnicity	
White	17 (57)
Black	3 (10)
Asian	5 (17)
Hispanic/Latina	2 (7)
Multiple ethnicities	2 (7)
Other	1 (3)
First exam also first women's health care visit?	
Yes	16 (53)
No	14 (47)
Location of first pelvic exam	
Doctor's office	1 (3)
Student health clinic	9 (30)
Gynecologist's office	20 (67)
Acuity of first pelvic exam	
Routine visit	20 (67)
Acute concern	10 (33)
First exam conducted by a gynecologist?	
Yes	19 (63)
No	11 (34)
Overall exam experience	
Positive	19 (63)
Negative	9 (30)
Neutral	2 (7)

Data are n (column %) unless otherwise specified.

Results

Demographic Characteristics

Thirty participants completed interviews. Median participant age was 22 (range 18-24) years and median age at first pelvic examination was 19 (range 16-24) years (Table 1). Nineteen participants described their first pelvic examination as overall positive, 9 described the examination as overall negative, and 2 were neutral.

Indication and Acuity

Ten participants had their first pelvic examination for acute indications, and 20 had their examination during routine care. Participants who had their first examination for acute indications believed their anxiety about the examination was less than their anxiety about their acute medical problem. One participant, who received her examination for a yeast infection, explained, “I think I just didn't care that much [about the examination], just because nothing could compare to the pain I was in. Like, it couldn't be that bad.” Participants who presented with acute concerns generally anticipated needing a pelvic examination, felt prepared to receive one, and were rarely caught off-guard when their provider recommended the examination.

Participants who received their examination during a routine visit were sometimes caught unawares when their provider recommended a pelvic examination. One participant reported this surprise and lack of time to dwell on the examination beforehand minimized her anxiety. “It was definitely good not to have months of forewarning… I think that would be the worst scenario, to be making it awful in my head, but I didn't have the time to do that.” Some who were surprised when their provider recommended the examination during routine care would have preferred time to prepare. “I feel like had I had more time to know okay I am going to do this and I have more time to think about it and prepare myself, then I probably would have felt a lot more comfortable.”

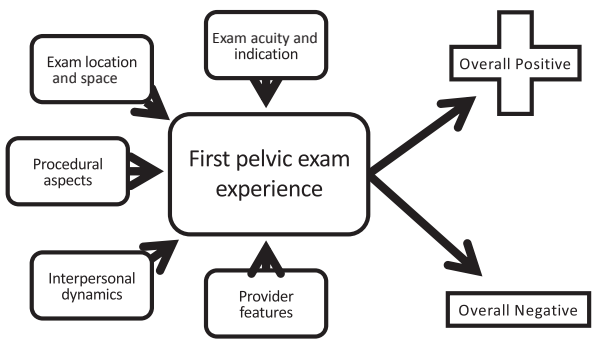

Fig. 1. Themes regarding factors influencing experiences during the first pelvic examination.

Location and Clinic Space

Several participants described how location or physical clinical space affected their experience. Many who spoke positively about the examination location received the examination in a familiar setting, such as student health. “I think it just made it smoother. I knew where to go. I recognized some faces and I had to go back independently a

few weeks later, and having had that positive experience emphasized that this [student health] is a reliable place, and I'm grateful that it's here." Other participants described how navigating large hospitals contributed to their negative experience. "The hospital's just so huge that it doesn't really—it always sort of implants this little bit of stress in me… Because I always start getting nervous like I'm going to be really late, and then they're just going to bump me off and then I'll have to wait another month or something."

The examination space also calmed some participants. One participant with a history of sexual abuse described seeking a clinic environment she believed would be calming:

> "The environment I think because it was spa-like, that totally took me out of the nervousness that I had experienced previously when I was, like, sitting on a vinyl chair in the waiting room at the [location of previous care], going in. Um, and I remember, like, I was not nervous at all for the pelvic exam."

This participant identified wood floors, soft lighting, refreshments, and pleasant music as positive features, echoing others who appreciated "nonclinical"-appearing examination settings. In contrast, several participants identified that obstetric and perinatal imagery and literature negatively affected their experience:

> "I hate the baby pictures in the gynecologist's. Because like some woman might need an abortion, and they are going there for it. Or like, sometimes that's weird but even if you're using a condom or other birth control, I still have this feeling, like what if I'm pregnant? And I see those babies and I hate them…. But it's like everywhere, and I think it's not good, yeah."

Provider Features

Participants also recognized the provider's age, gender, and race/ethnicity, as potentially contributing to their exam experience. Participants appreciated relating to younger providers:

> "She seemed younger and like maybe she would still be able to listen to me a little bit more. Because all the doctors who haven't listened to me in the past have all been a couple generations older than me."

Participants also favored having a female provider perform the first pelvic examination:

> "I think in general it's just because if you have to talk to them about certain things that might be embarrassing or uncomfortable, I think for me it's nice because a female has likely experienced it or can empathize with you in a way that like, a male gynecologist wouldn't be able to."

Regarding a provider's race/ethnicity, participants of color in particular reflected on how racial/ethnic concordance or discordance influenced their comfort during the exam. One participant, who obtained her exam for pelvic pain, explained how having a provider of color put her at ease:

> "I think already being in a position that knowing something was wrong, I would have appreciated any kind of familiarity, and she, you know, she kind of looks like me and I could see from her picture from the Web site that she did. Even though she wasn't a black woman. I'm half black, half white, but that was something that I was kind of—I was also kind of excited to see women of color in high positions in the medical community."

Interpersonal Considerations

Individuals with a previous relationship with the provider who performed their first exam described how this relationship improved their comfort and overall experience.

> "Because I knew what the office was like and I kind of knew what his manner was, like going into it because I had met him before but not very extensively… And when I came back the second time I felt like I kind of knew him, so it was better definitely that I got to go in before and not get an exam."

Several participants with a negative experience indicated that not having a previous relationship with the provider was an important contributing factor:

> "I've found that I take value in the relationships that I built—I build—with my health care providers, so rather than just having a stranger I guess you know all of your doctors are strangers at some point, but I don't think they should be for your first pelvic exam, because there's a lot of emotion that goes into that and a lot of feeling and it helps to meet the person beforehand and have that one-on-one so you're put at ease and you're not so nervous because if you at least know the face before just them being dropped into your room."

Nearly half of participants would have preferred a previous appointment to establish care with the provider. However, many remarked that having 2 appointments would have been an unacceptable burden for relatively little benefit:

> "I think it would have been helpful in getting more comfortable with the doctor, but in terms of what to expect you just, you really don't know until you're there and you're getting the exam."

When asked to narrate the examination experience, many reflected on interactions with their provider before the examination and provided little narration about the actual examination. Most participants emphasized the important role that discussions with providers immediately before the examination played in setting up their overall experience. The provider's demeanor, interpersonal skills, and communication before the examination strongly contributed to their experience during the examination. When asked about the relative importance of interactions before vs during the examination, one participant explained,

> "I want to say the lead up [was more important], because that's what I remember more, is kind of talking to her before and after. Actually doing it, I don't have as clear of a memory of, so I want to say—it clearly was not something that I was miserable during, otherwise I'd probably remember that."

A provider's warmth, openness to questions, and in-depth explanations positively influenced the remainder of their experience. A provider's inability to invoke these relationship-building elements before the examination negatively affected participants' comfort during the examination:

> "I would have liked her explaining a little more to me about what I was going to be expecting. Especially before would have been really good and even during to go a little slower and tell me exactly what's happening… Because as I said before I was like really uncomfortable and I am very uncomfortable with people, touching me. So having her explain it before would have helped mentally prepare me and physically prepare me during."

Procedural

Despite redirection and specific prompts to elicit descriptions of the physical steps of the examination, some participants did not recall procedural details about the examination. Many endorsed first meeting their provider while dressed put them at ease for the examination.

> "That [meeting her provider in street clothes] was way better. Because at student health here I've had to be in my gown when I meet the doctor, and that's a lot. Because the power dynamic is so different, and it's like you already feel very exposed. Just having that interaction, and then especially if you're already in a gown."

Another participant who met her provider already gowned explained,

> "I think it definitely made me feel vulnerable from the outset, so it took more for her to get me to feel comfortable. Um, rather than, um, rather than had I met her clothed, if that makes sense."

Procedural factors that received little mention or were less impactful included draping/gowning and interactions with clinic staff. Many had no memory of these features or remarked they had little effect on their experience. When asked if draping/gowning affected her experience, one participant answered,

> "Um, not really, but I mean probably it was better than just like, what's the point of having the gown if you're not going to use it? Right? So, it's probably better than just sitting there naked, like that would probably be an odd experience [laughs]… But I didn't think about it at the time. Thinking back, it's probably good [laughs]."

Participants also viewed the presence/absence of a chaperone as contributing little to their examination experience. Only 5 participants remembered a chaperone being present during the examination. When present, individuals underscored the importance of meeting the chaperone before the examination. One participant compared her first examination, with a chaperone, to her second examination, without a chaperone:

> "I think [the first exam, no chaperone] was more comfortable and I liked that a lot better. Like when I saw the second dude there was someone in the room and that made me uncomfortable, just because it wasn't explained who she was or why she was there. She was just kind of standing there and it was kind of weird that she was there, because it's more difficult to have open communication when you have literally no idea what another person in the room is doing there."

Recommendations for Providers of First Pelvic Examinations

When concluding the interview, participants were asked, "If you were speaking to someone who was going to perform first pelvic examinations in the future, what would you want them to know?" Major recommendations included: (1) establish rapport and educate before the examination; (2) institute practices to orient individuals; (3) make no assumptions about identity; and (4) elicit continuous feedback.

Participants urged future providers to take time to connect before conducting the examination. Participants also emphasized that providers not assume previous knowledge about the pelvic examination and explain why the pelvic examination was needed and how the examination is supposed to feel.

> "So asking people not only do they have any questions, but also saying, "Oh if it's okay, I'm going to give you a run-down of how this is going to go. If you already know, feel free to tell me to shut up and then we'll just do the procedure." But giving me the option of please, just being educated about it for a minute would have made such a difference."

A few participants offered that they would have benefitted from Web sites, videos, patient stories, or workshops explaining the pelvic examination to young patients.

> "I think—I think there should definitely be more public, medically accurate information that's easily accessible for women across everything. Like, pelvic exams, sex, birth control, and uncensored information—I feel like that's something that's lacking a lot of the time and I feel like that perpetuates the stigma that a lot of women feel going into, yeah, pelvic exams, or any kind of gynecological anything."

Clinic practices they believed would have improved their experiences included meeting before changing into a gown, allowing a family member/friend be present during the examination, and explaining how to change into the gown. "I wish they had given more guidance with the basic stuff because the nurses expect you've done everything before."

Participants urged providers to adopt nonjudgemental stances toward patients and implement clinic polices reflecting openness to their identities. One participant who identified as nonbinary explained,

> "Just like, gay shit. Even just some sort of cheesy poster or the safe space stickers, you know? That seems simple, but like, or again this feels stupid in a gynecologist's office, because they're dealing with people with vaginas, but using they/them pronouns as a default is probably like, hey you know the queer things, you're up on what's happening…"

Finally, participants urged providers to be aware of their patients' reactions during the examination, check in constantly, and be sensitive to how the examination could trigger individuals who have experienced sexual trauma. A participant with a previous sexual assault explained,

> "Dissociation is possible and so I think checking in during the exam is really important and making sure that thing is okay. Because something can be okay before the exam or after the exam but it's really important that the person is able to be present."

Discussion

In this study we sought to elicit factors that influenced adolescent and young adults' experiences during their first

pelvic examination. Although nearly two-thirds of participants described an overall positive examination experience, one-third reported a negative experience. Factors influencing the examination experience included patient-level factors (examination acuity and indications) and provider-level factors (location and physical examination space, provider demographic characteristics, interpersonal skills, and procedural aspects of the examination).

This study updates and expands the limited body of research on this topic.[3–8] Previous research has examined the role that the provider's sex plays in individuals' examination experiences. A German survey on factors associated with pain and anxiety with the first pelvic examination showed no relationship between examiner's sex and examination experience.[6] In contrast, a British survey echoed our findings that participants favored having a female provider for their first pelvic examination.[11] This British study also reported the presence/absence of a chaperone was not associated with pain or anxiety during the examination.[11] Although our participants indicated that the presence/absence of a chaperone contributed little to their experience, these findings should be interpreted cautiously, because of the recommendations of ACOG and the American Academy of Pediatrics that a chaperone be present during pelvic examinations.[12,13]

This study underscores the primacy of interpersonal skills in how individuals experience the first pelvic examination. Notably, despite probes seeking to elicit information about physical aspects of the examination, participants focused their discussion on relational aspects of the examination. Several previous, smaller studies also showed that establishing a trusting relationship with the provider and receiving continuous information before and during the examination put patients at ease during their first pelvic examination.[7,14] These findings echo our previous report describing factors influencing adolescent and young adults' preparedness before the first pelvic examination that underscored the important role that information played in helping prepare individuals ahead of their examination.[15] Participant recommendations also focused on informational and interpersonal aspects of the examination and did not delve into specific technical aspects of the examination.

Limitations of this study must be considered. Despite efforts to expand the pool of potential participants, participants were largely college-educated and more than half were white. Consequently, our findings might not translate to individuals from backgrounds under-represented in our sample. Because participants were recruited using flyers and e-mails inviting individuals to discuss their first pelvic examination, individuals might have participated because of strong positive or negative examination experiences, introducing selection bias. Finally, although this qualitative study identified salient themes about experiences with the first pelvic examination, this methodology does not quantitatively analyze the relationship between certain factors and whether patients have a positive or negative examination experience. A larger, quantitative study is needed to conduct such analyses.

Despite these limitations, this study generates hypotheses regarding how to optimize the first pelvic examination. Unique to this study, we explicitly sought participants' recommendations to improve the examination experience. Although providers might not be able to alter the indication acuity, participants stressed the importance of clearly explaining why a pelvic examination is needed and support ACOG's recommendations to only conduct a pelvic examination when medically indicated before the of age 21 years.[1] Participants also valued spaces that reflect the needs and identities of diverse patients, including minimizing obstetric materials and including materials that celebrate lesbian, gay, bisexual, transgender, and gender queer individuals. Only 3 of our 30 participants openly self-identified as nonheterosexual. Two of these 3 participants emphasized that having a provider who normalized their identity and experiences was of the utmost importance to their having a positive first examination. However, additional research is warranted to further explore the first pelvic examination experiences of lesbian, gay, bisexual, transgender, and queer patients and factors that might enhance their experiences with this examination. At the procedural level, participants highlighted implementable practices—explaining the nature of the examination before asking patients to undress, instructing on gowning, and allowing friends/family in the room during the examination.

Finally, participants' narratives and recommendations identify a deficit in interpersonal communication skills specifically around conducting the first pelvic examination. In one study assessing obstetrician–gynecologists' perceived adequacy of training in adolescent health care, most respondents reported receiving inadequate or no training on addressing sensitive issues such as psychosocial development and confidentiality with adolescents.[16] Recommendations and curricula to improve communication and conduct the pelvic examination in the adolescent population do exist.[17–21] However, this study underscores the need for greater training on communicating with adolescents and young adults before and during the first pelvic examination.

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