Published in final edited form as:

J Midwifery Womens Health. 2012 ; 57(5): 489–494. doi:10.1111/j.1542-2011.2012.00187.x.

Falling Out: Authoritative Knowledge and Women's Experience with Pelvic Organ Prolapse

Lisa Kane Low, PhD, RN, CNM and Julie A. Tumbarello, MA, CCRP

Abstract

Introduction—Despite the high prevalence of pelvic organ prolapse many women suffer in silence, lacking the language and opportunity to describe their condition. There are limited descriptions of women's experiences with pelvic organ prolapse in the literature. This qualitative study addressed the knowledge and experience of women with pelvic organ prolapse.

Methods—Semi-structured interviews were conducted with 13 women who had been previously diagnosed with pelvic organ prolapse. Transcripts of the interviews were reviewed and coded using a process of content analysis compared against the framework of authoritative knowledge, developed by Bridgitte Jordan.

Results—By applying the concept of “authoritative knowledge,” we identified three themes of how women construct understanding about their pelvic organ prolapse and how they demonstrate deference to the authoritative knowledge of medical providers. First, we found through women's narratives that authoritative knowledge was held by the health care provider and is considered consequential and legitimate by all participants. Second, women reported that the health care provider's authoritative knowledge was valued over personal, experiential knowledge. Finally, women describe how they work with their health care providers to create a system of authoritative knowledge as they seek treatment for or discuss their condition. Throughout the narratives, women's experiences are not well acknowledged by themselves or the medical community, perpetuating the “hidden” nature of these conditions.

Discussion—This analysis provides qualitative evidence of Jordan's authoritative knowledge: women and health care providers contribute to dimensions of authoritative knowledge surrounding pelvic organ prolapse. Despite what women experience, the health care provider's definition and understanding of pelvic organ prolapse is seen as legitimate and consequential. Because of their construction of their condition, and the power dynamic at play, women are silenced and their expertise about their body is delegitimized, limiting their active participation in seeking care for this condition.

Keywords

Pelvic floor dysfunction, prolapse, embodiment/bodily experiences; health care, users' experiences; knowledge construction; lived experience; women's health, midlife

Corresponding Author Lisa Kane Low PhD CNM FACNM 400 North Ingalls Suite 3320 Ann Arbor, MI 48109 Phone: (734) 647-0136 Fax: (734) 647-0351 kanelow@umich.edu.

Conflict of Interest: The authors have no conflicts of interest to disclose.

INTRODUCTION

Pelvic organ prolapse is a condition unique to women that is not articulated as well as other pelvic floor dysfunctions such as incontinence. Pelvic organ prolapse occurs when muscles, ligaments, and other tissues that support the pelvic organs become weakened or damaged.¹ The causes of pelvic organ prolapse are multi-factorial and have been linked to specific events such as a traumatic birth (e.g. use of forceps), lifestyles that include prolonged standing or heavy lifting, as well as the normal aging process.² The organs most affected by prolapse are the bladder, uterus, vagina, and rectum.³ Many women are asymptomatic, but when the problem is experienced, they describe uncomfortable symptoms that include a sensation of a bulge or fullness in the vagina, feeling “*like a tampon is falling out*”, pelvic pressure, groin pain, lower back pain, painful intercourse, difficult bowel movements, urinary or fecal incontinence, and sexual dysfunction.⁴ Treatment for prolapse ranges from non-invasive therapies such as pessaries to varied surgical interventions; repeated surgeries are often necessary for symptom relief.⁴ Pelvic organ prolapse can also negatively impact a woman’s sense of her sexual health and body image.^{5,6} However, due to potential embarrassment, misinformation, cultural and personal silence concerning this condition, women are often reluctant to seek treatment for these problems.⁷

With the help of consumer advocacy groups, the topic of incontinence has moved from medical journals to popular media, yet the same public promotion has not taken place with pelvic organ prolapse. Because of limited information in public discourse and inadequate lay language surrounding the topic, a gap exists between how women understand their complications and how prolapse is discussed within the biomedical community⁸. While communicating, or naming, an experience provides significance, the gap in language and the power differentials between women and health care providers limit what women share and how it is shared.⁹ Consequently, medical and social marginalization of women who experience pelvic organ prolapse can result.

To better understand this complex interplay between a woman’s symptom experience with pelvic organ prolapse, her ability to communicate and seek treatment for the condition, and her construction of new knowledge about her health condition, we applied the analytical framework of authoritative knowledge described by Brigitte Jordan¹⁰ to women’s narratives regarding the experience of being diagnosed with pelvic organ prolapse. Through the use of semi-structured phone interviews conducted with women who have pelvic organ prolapse and who had sought medical services for their condition, we explore their experiences using the framework of authoritative knowledge. Through this process we seek to identify current limitations of the understanding of women’s experience of pelvic organ prolapse in today’s health care environment.

Authoritative Knowledge

In Bridgett Jordan’s 1978 book, *Birth in Four Cultures*, she compares birthing systems in United States, Sweden, Holland, and the Yucatan.¹⁰ One of the main theoretical concepts she developed to compare these systems was that of authoritative knowledge. According to Jordan:

“For any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for purposes at hand (“efficacy”) or because they are associated with a stronger power base (“structural superiority”), and usually both”.¹⁰

While there is great complexity in how these systems are defined and how consumers associate themselves with them,¹¹ the public tends to assign an inherent structural superiority to the medical system. Jordan defines authoritative knowledge as a system that gains dominance over all others because the participants agree it “counts in a particular situation”.¹⁰ In her view, the health care providers possess authoritative knowledge because within the social and cultural structures, their biomedical knowledge is socially endorsed over other systems of knowledge, not because their knowledge is always correct. In other words, individuals see this knowledge system as consequential, a platform upon which they can “make decisions and provide justifications for course of action.”¹⁰ Jordan writes, “It is the knowledge that within a community is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions.”¹⁰

According to Jordan, individuals or entities with the authoritative knowledge have it because: a) they explain “the state of the world better for purposes at hand (“efficacy”)” and/or b) those not in power associate them with “structural superiority”.¹⁰ Those with the authoritative knowledge have what is believed to be, legitimate information and therefore can define health or illness.¹² The knowledge of the health care provider is positioned within Western societies as authoritative and “seen as legitimate, consequential and to the point.”¹⁰ Legitimizing one way of knowing as authoritative often results in devaluing or dismissing all other ways of knowing and in particular the experience of the patient is often devalued.¹⁰ Specifically noting women’s experiences of childbirth, Jordan points out that authoritative knowledge

“... supersedes and de-legitimizes other potentially relevant information sources such as the woman’s prior experience and the knowledge she has of the state of her body. This kind of knowledge is suppressed and de-legitimized by all participants including the woman herself”.¹⁰

Jordan argues that women often “willingly submit themselves to the authority of the medical view” as a consequence of the manner in which authoritative knowledge is constructed and maintained by social structures and the cultural valuing of such systems.¹⁰ In this manner, Jordan argues, people not only accept authoritative knowledge but are actively engaged in the process of its production. In summary, it is not that authoritative knowledge is inherently correct or better, it is that individuals allow themselves to determine meaning or consequences over other ways of knowing.

METHODS

Sample

Participants for this study were drawn from a pool of 286 women who had participated in a parent clinical study of pelvic organ prolapse.² The parent investigation, conducted between

November 2000 and October 2004, recruited women to participate in a study of soft tissue defects that lead to pelvic organ prolapse. The parent study was approved by the University of Michigan Medical School Institutional Review Board, and all subjects signed an informed consent document. The study used a case-control approach with groups matched for age, race, and hysterectomy status. The sample consisted of 151 women with prolapse (cases) and 135 controls with “normal” support as determined by pelvic organ prolapse quantification examination.²

In 2008, a separate institutional review board approval was obtained to conduct this study to explore how women comprehend, conceptualize and communicate their experiences with pelvic organ prolapse. Given the time delay from the initiation of the parent project and the initiation of this project, along with other follow up investigations by the same research team, only 62 women were re-contacted for possible interest in this or another study. Of those, 28 women had a diagnosis of prolapse, with and without surgical intervention, and were potentially eligible, but not all agreed to participate further. We planned to conduct in depth interviews with up to 14 women (7 women who had surgery after the study and 7 women who had not had surgery). After initial contact, verbal informed consent for participation in this project was secured, including consent to tape record the interviews.

Data Collection and Analysis

Interviews were conducted by a research coordinator and a research nurse-midwife both with backgrounds in qualitative interviewing techniques. Each interview was conducted over the phone and recorded. Through open-ended and semi-structured questions (provided in Table 1), we explored how women identified, experienced, and sought medical care for pelvic organ prolapse. Interviews lasted between 20 to 60 minutes, and then were recorded and transcribed. Transcripts were read by all members of the research team, which included 2 certified nurse midwives and a research coordinator who is not medically trained. The initial reading of the narratives allowed for general ideas and initial themes to be considered. It was during this process of initially reviewing the transcripts that the decision to employ the analytical framework of authoritative knowledge was made. The members of the research team were familiar with this concept as used in other health related arenas, particularly childbirth. At this time, a review of the framework was completed and a coding scheme was developed to explore whether or not the tenets of authoritative knowledge were present. After this, members of the research team read each transcript a second time and entered values into Atlas.ti (2007 Scientific Software Development, Berlin), a software program for organization of qualitative data.

Using a line by line approach, as described by Glaser and Strauss,¹³ open codes were identified throughout the transcripts. Each transcript was read by two of the research team members and coded. Agreement on coding was accomplished by asking a third member of the research team to verify the coding process if there were any areas of disagreement between the original two coders. Consensus on the coding process was reached through discussion with the full research team. Once the coding process was completed, the list of codes was collapsed into related categories. The next steps were informed by use of the tenets from the authoritative knowledge framework. We looked at the categories and

considered whether they were consistent or inconsistent with the framework of authoritative knowledge. Throughout this process, we maintained internal reliability by reaching consensus among all members of the research team. Through this process of content analysis,¹⁴ a final identification of themes was completed. Finally, overall themes were identified and analyzed against the tenets of authoritative knowledge as described by Jordan.

RESULTS

The final sample of 14 included 9 women who had not had surgery and 5 women who had surgery. Although we had intended to recruit an equal mix of women who had and had not had surgery as a form of treatment for prolapse, most women contacted managed their symptoms with a pessary or were just living with the complications. Of the 9 women who did not have surgery, one interview was terminated early because the subject did not have knowledge of her condition and did not have any symptoms. Thus, a total of 13 women completed interviews.

All the women were white and ranged in age from 33-81 (mean 57.4). Twelve had given birth vaginally; one via Caesarian. All births were successful. The mean number of vaginal births was 3.2.

Three recurring themes were identified throughout the women's narratives. First, authoritative knowledge is held by the health care provider and is considered consequential (worthy of taking action) and legitimate by all participants. Second, the health care provider's authoritative knowledge is valued over experiential knowledge. Lastly, authoritative knowledge is constructed and reinforced by both health care providers and the women themselves as they seek treatment for or discuss the diagnosis of their condition.

Authoritative knowledge is held by the health care provider

Lack of information, language, and a framework for pelvic organ prolapse lead women to seek out an opinion from someone seen as an authority such as the health care provider, when something is perceived as "not right down there" in order to have their condition named. For example, one woman said "I went to my primary care physician first and explained to her [my symptoms], and then she said, she told me what it was". Because of the cultural silence and lack of information on prolapse, this woman, like so many others, had an experience that she could not name herself.

Consistent with Jordan's description of authority, health care providers are in the position to diagnose the condition of prolapse. Several women commented that even though they were not experiencing any discomfort or symptoms, a label came from their health care provider.

"I never felt it. In fact I never paid any attention until the doctor said, "Have you ever put a mirror down there?" And I said, "No." And he's like, "When you go home tonight you're to sit down, take a mirror down there and I want you to look and cough and you'll see exactly what I'm talking about." And, it was more of a bulge. And I never felt it, never. I never really had any issues. That's why I never knew it was there."

When the label does not come from a woman's own experience, it can lead to surprise and disbelief, "I was pretty much taken aback when I was informed that I actually had something going on... When I was first diagnosed with this I thought, 'Ok. That's a bit of a stretch' because I had no other symptoms."

Health care provider authoritative knowledge is valued over experiential knowledge

Another theme documented from the narratives was that women assign authoritative knowledge to their health care provider over other types of knowledge, specifically their own experiential knowledge. Some women know they have prolapse and seek a diagnosis, but, when they do not meet the medical definition, they are told nothing is wrong. For example, one woman knew she had prolapse but providers were not willing to label it as such. After the birth of her first child, she felt "different" and "uncomfortable." She was told that these feelings would eventually go away. When they didn't, she went to see a provider who dismissed her experiential knowledge. When asked if she sought help after the first provider, she responded, "No, I guess I really didn't talk too much to professionals about it after I was told, kind of, 'No. Nothing there.' And then the second pregnancy they realized, yup, they realized it". Her experience told her something was different with her body and yet it was dismissed and seen as irrelevant the first time she asked questions about it.

Authoritative knowledge is constructed and reinforced by health care providers and women themselves

The third theme identified was that authoritative knowledge is constructed and reinforced not only by those with authority, but by the women themselves. According to Jordan "... people not only accept authoritative knowledge but are actively and unselfconsciously engaged in its routine production and reproduction." In these interviews, women accepted what their health care providers offered even though their own experiences were contradictory. When women reflectively question the information or diagnosis offered by the provider, it is done so indirectly. For example, the following woman's acceptance of treatment options, regardless of skepticism and questioning, actually reinforces and reproduces authoritative knowledge while ignoring her own experiential cues. She stated:

"I'm not blaming [the doctor]. I'm just saying that now I'm thinking that maybe they should pursue it a little bit more, you know, for people who have had the problem. And I don't know why they did or why they don't. I mean I'm not the doctor and I don't know why. I'm not questioning them at all, but I just wished that they would have taken care of it, if there was a way, an additional way. "

This woman, like many others, may not be an active agent, but is also not a victim; she says "*I'm not questioning them.*" In these previous two examples, each woman accepted what their health care provider offered even though their experience told them something different. Even when a woman reflectively questions the information or diagnosis provided by the physician, it is done so indirectly, as indicated in the following example of a woman who had an unsuccessful prolapse repair, and wanted it fixed. She said, "It's uncomfortable and my doctor told me 'You're already managing pretty well.'" . The doctor's words, along with the woman's unquestioning acceptance, demonstrate how her experience is diminished, even erased. Or in another case, a woman did not have any initial symptoms when she was

diagnosed with prolapse, but she then began to associate specific feelings and sensations with it even though she does not use the term “prolapse.”

Through acceptance of recommendations or what could be described as women’s inaction to find alternative treatments or opinions, they in turn reinforce the authoritative knowledge system. Rather than coming to a joint understanding of what is occurring, there is no negotiation of meaning between the woman and the health care provider, the discussion begins and ends with the physician’s diagnosis.

Another woman experienced urge incontinence and was told that she didn’t have urinary issues:

“Like the urinary specialist I went to..., I was really crushed. I’d waited three or four months to get an appointment with her...So when I got the appointment to be told, ‘Yes, there’s absolutely nothing wrong with you as far as urinary concerns’ because I had this urge incontinence thing. But to be told ‘you’ve got a rectocele’. ‘What is it?’ ‘Oh, you don’t need to know.’ Well, hey, if it’s to do with you, you’re the one person who needs to know about it. You shouldn’t be sort of kept like, ‘Oh, you’re a child being a nuisance. Go away. You don’t need to know.’”

According to this woman, she was not provided with enough information, but was instead silenced and treated in a demeaning manner. In these examples, consistent with the Jordan’s framework, authoritative knowledge is accepted because experiential knowledge is considered secondary or inconsequential by both the health care provider and women themselves.

DISCUSSION

Using Jordan’s concept of authoritative knowledge, themes were identified from within women’s narratives regarding pelvic organ prolapse that support the tenets of this framework. Health care providers in this investigation held the authoritative knowledge and, thus, their definition and understanding of pelvic organ prolapse was seen as legitimate and consequential. Whether or not women experienced symptoms of pelvic organ prolapse, the provider’s authoritative knowledge was valued over the woman’s experience. Finally, not only do health care providers construct and reinforce authoritative knowledge, but women themselves do so through their actions and inactions. Thus the manner in which authoritative knowledge is demonstrated in this study results in a process of privileging the health care providers’ diagnosis and naming of the condition over the reality of what women are feeling, negating their experiential knowledge.

For women who did not have any symptoms, naming the condition did not provide any additional insights into a need for treatment or prevention. This raises the question of whether there is a need to name the condition of prolapse if the woman does not have symptoms To name or diagnosis a condition is of value in a biomedical framework and is the work of the health care provider, an extension of their authoritative knowledge. But this may not carry the same value to the individual who is not bothered by the condition. Naming it may actually create greater concern, anxiety or cause the development of body image

issues that previously did not exist prior to the naming by the medical care provider. Prior studies have noted the challenges of diagnosing prolapse, with reports of up to 50% of women being asymptomatic at the time of diagnosis by their primary care provider.⁸ Doctors who use prolapse quantification (POP-Q) measures can identify prolapse in conditions when women are unable to self-diagnose. This differential raises the question of whether the standardized measure accurately captures the condition of prolapse in the absence of being combined with women's experiential knowledge or experience of symptomatology. Alternatively, if naming the condition is combined with an opportunity for education and prevention of worsening symptoms then it could be argued that it provides a value that supersedes a woman's experiential knowledge. However, this was not the outcome of several of the provider-client interactions reported in this study.

Studies evaluating the relationship between degree of pelvic organ prolapse and specific symptoms, such as vaginal bulging, pelvic pressure, and voiding dysfunction, have found only weak to moderate correlations.¹⁵⁻¹⁸ However, in this study, despite the limitations of medical knowledge and the inexact nature of diagnosing pelvic organ prolapse, authoritative knowledge was considered more authoritative than the woman's own experience.

Exemplars of the role of authoritative knowledge in other aspects of women's health care have included experiences with prenatal diagnosis, childbirth, and menopause. Recently it has manifested into the ways in which members of the medical system use technology, which may lead to a patient deferring to the authority of the device, despite its quality and reliability.¹⁹ In the context of women's experiences of pelvic organ prolapse, technology is not viewed as a critical aspect of the diagnosis. This places the provider in a more prominent, authoritative position as the individual with the assumed skills to make the diagnosis of prolapse.

Limitations

The sample represents a health-seeking population which is not inclusive of all women who experience this condition. Women who do not access the health care system may have very different experiences and might be less inclined to accept health care providers' authoritative knowledge. All the participants had experience with prolapse so were used to the term, either within the context of the parent study or through their health care visits. An additional limitation of the generalizability of the study is the ethnically and racially homogeneous sample. Lastly, telephone and not face-to-face interviews may be considered a limitation but for topics of a sensitive nature, phone interviews provide distance between the interviewer and the participant, thus allowing her to answer more honestly.

Clinical Implications

In this investigation we have confirmed that the bio-medical knowledge is considered authoritative over women's experiential knowledge. Other investigations have raised concerns regarding how biomedical discourses about specific health conditions have become so infused into the lay community that a woman's experience or self-concept of her condition is devalued and even ignored.²⁰ This infusion of biomedical knowledge and its unquestioned adoption by the lay community is supported by the women in our study. .

Although Jordan believes that it is possible to have “equally legitimate, parallel knowledge systems...where people move easily between them,”¹⁰ how do we achieve this type of balance with the complex issue of pelvic organ prolapse?

Regarding pelvic organ prolapse, women’s experience and medical knowledge can both experience legitimacy in clinical midwifery practice. To make this possible, first use the language women use to describe pelvic organ prolapse. For example, the women we interviewed used descriptive terms like “falling out” and “sagging”. As one woman summarized it, “You know your insides feel like they are falling out...I found that it was difficult for me to lift because I felt like anything, you know, it would make it feel like everything was falling out more.” Next, when providers speak with symptomatic women, they need to use this experiential language in conjunction with medical terminology. Third, midwives can acknowledge that the medical system categories of prolapse do not necessarily correlate with the inconvenience afforded by the symptoms. For example, having the most severe type of prolapse does not necessarily correspond to the worst quality of life or symptoms. The opposite can also be true: a woman with the least severe category of prolapse might find the condition unbearable within the context of her life experience. Furthermore, the use of standardized prolapse quantification measures such as the POP-Q, absent women’s experiential knowledge, may lead to either an over or under diagnosis of the condition ignoring the actual consequences of both on women’s body image and sense of quality of life.¹⁸ Women’s actual experiences need to be acknowledged which is consistent with the midwifery model of care and how midwives practice, listening to women as the primary informants regarding their health and wellness.

In summary, to avoid the risk of negating women’s experience, midwives and all health care providers need to seek continued assessment of women’s experiences with their physical symptoms and the impact they have on their lives, even though these might not fall within the biomedical criteria for prolapse diagnosis. And finally, while this study is a very small start, we need further research exploring women’s experiences with pelvic organ prolapse.

Acknowledgments

The author’s wish to thank Ruth Zielinski for her participation in conducting interviews and members of the University of Michigan Pelvic Floor Research Group for their peer review and suggestions in the development of this manuscript.

The author(s) disclosed receipt of the following financial support for the research and/or authorship of this article: Project support from NIH Grant RO1 HD 038665. Investigator support from The Office for Research on Women’s Health’s SCOR on Sex and Gender Factors Affecting Women’s Health and the National Institute of Child Health and Human Development through grants P50 HD044406.

Biography

Bios Lisa Kane Low, PhD, RN, CNM, FACNM, is an assistant professor in the School of Nursing and Women’s Studies Department and Director of the Midwifery Education Program at the University of Michigan in Ann Arbor, Michigan, USA.

Julie A. Tumbarello, MA, CCRP, is the Project Manager for the Pelvic Floor Research Group and Department Research Manager for the Department of Obstetrics and Gynecology at the University of Michigan in Ann Arbor, Michigan, USA.

References

1. DeLancey JO, Kane Low L, Miller JM, Patel DA, Tumbarello JA. Graphic integration of causal factors of pelvic floor disorders: an integrated life span model. *Am J Obstet Gynecol.* 2008; 199(6): 610–614. [PubMed: 18533115]
2. DeLancey JO, Morgan DM, Fenner DE, et al. Comparison of levator ani muscle defects and function in women with and without pelvic organ prolapse. *Obstet Gynecol.* 2007; 109(1):295–302. [PubMed: 17267827]
3. Jelvosek JE, Maher C, Barber MD. Pelvic organ prolapse. *Lancet.* 2007; 369(9566):1027–38. [PubMed: 17382829]
4. Machin SE, Mukhopadhyay S. Pelvic organ prolapse: review of the aetiology, presentation, diagnosis and management. *Menopause Int.* 2011; 17(4):132–6. [PubMed: 22120945]
5. Lowenstein L, Gamble T, Sanses T, et al. Sexual function is related to body image perception in women with pelvic organ prolapse. *J Sex Med.* 2009; 6:2286–2291. [PubMed: 19493287]
6. Zielinski R, Kane Low L, Tumbarello JA, Miller J. Body Image and Sexuality in women with prolapse. *Urol Nurs.* 2010; 29(4):239–246. [PubMed: 19718939]
7. Sasso KM. The Colpexin Sphere: a new conservative management option for pelvic organ prolapse. *Urol Nurs.* 2006; 26(6):433–40. [PubMed: 17253077]
8. Lewicky-Gaupp C, Margulies R, Larson K, Fenner D, Morgan D, DeLancey JO. *Urogynecol J Pelvic Floor Dysfunct.* Aug; 2009 20(8):927–931. doi:10.1007/s00192-009-0890-1.
9. Kane Low, L.; Schuiling, KD. Women's health from a feminist perspective. In: Schuiling, K.; Likis, F., editors. *Women's Gynecologic Health.* Jones and Bartlett Publishing; Sudbury, MA: 2005.
10. Jordan, B. *Birth in Four Cultures: A Cross-cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States.* Waveland Press, Inc.; Prospect Heights, IL: 1993.
11. Hughner RS, Kleine SS. Variations in lay health theories: Implications for consumer health care decision making. *Qual Health Res.* 2008; 18(12):1687–1703. [PubMed: 18955468]
12. Starr, P. *The Social Transformation of American Medicine.* Basic Books; New York, NY: 1982.
13. Glaser, BG.; Strauss, AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Aldine Publishing Company; Chicago, IL: 1967.
14. Morgan DL. Pearls, pith, and provocation: qualitative content analysis: a guide to paths not taken. *Qual Health Res.* 1993; 3(1):112–121. [PubMed: 8457790]
15. Barber MD. Symptoms and outcome measures of pelvic organ prolapse. *Clin Obstet Gynecol.* 2005; 48:648–661. [PubMed: 16012232]
16. Ellerkmann MR, Cundiff GW, Melick CF, Nihira MA, Leffler K, Bent AE. Correlation of symptoms with location and severity of pelvic organ prolapse. *Am J Obstet Gynecol.* 2001; 185:1332–1338. [PubMed: 11744905]
17. Ghetti C, Gregory WT, Edward SR, Otto LN, Clark AL. Pelvic organ descent and symptoms of pelvic floor disorders. *Am J Obstet Gynecol.* 2005; 193:53–57. [PubMed: 16021058]
18. Swift SE, Tate SB, Nicholas J. Correlation of symptoms with degree of pelvic organ support in a general population of women: what is pelvic organ prolapse? *Am J Obstet Gynecol.* 2003; 189:372–379. [PubMed: 14520198]
19. McCoyd JL. Authoritative knowledge, the technological imperative and women's responses to prenatal diagnosis diagnostic technologies. *Cult Med Psychiatry.* 2010; 34(4):591–614.
20. Hyde A, Nee J, Howlett E, Drennan J, Butler M. Menopause narratives: the interplay of women's embodied experiences with biomedical discourses. *Qual Health Res.* 2010; 20(6):805–815. [PubMed: 20181821]

Table 1

Semi-structured questions used for participant phone interviews

- 1 How would you describe prolapse?
 - 2 Tell me about when you first noticed the prolapse: when did you first notice it, what did it feel like, and what did you think it was?
 - 3 In your opinion why do you think this happened?
 - 4 How did you feel once you noticed it (physically, mentally, emotionally)?
 - 5 Did you talk with anyone about this? If so, who? If no, why not?
 - 6 If you did talk to someone, did they suggest any treatment or explain why this was happening?
 - 7 Did you seek treatment? Why/why not?
 - 8 How long after you noticed did you seek treatment? What amount of time passed?
 - 9 Tell me about what types of expectations you had when you sought treatment.
 - 10 Who did you go to for treatment? Why?
 - 11 Tell me about the kinds of information you were given and what kind of information you wish you had been given.
 - 12 How did you first come to understand that you had prolapse and how did you get information about it?
 - 13 How do you view your body in relationship to prolapse. Has the way you think about your body changed at all? Can you explain....
 - 14 After you knew what was happening to you did you discuss this with anyone else? Why did or didn't you talk about with them?
 - 15 Have you ever had a negative experience when you have talked about prolapse with other people.
 - 16 Have you ever had a positive experience when you talked with someone about prolapse?
 - 17 Did/Does prolapse impact any part of your career or social life?
 - 18 Where did/does pelvic organ prolapse fit into the hierarchy of needs such as children, work life, etc.?
 - 19 After experiencing prolapse yourself, how do you view other women with prolapse?
 - 20 Why do you think women do or do not discuss prolapse with others?
 - 21 Is there anything else that we didn't touch on that you think we should have?
-