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The Emotional Burden of Pelvic Organ Prolapse in Women Seeking Treatment: A qualitative study

Chiara Ghetti, MD, MSc^{1,2}, Laura C. Skoczylas, MD, MSc^{1,3}, Sallie S. Oliphant, MD, MSc^{1,4}, Cara Nikolajski, MPH⁵, and Jerry L. Lowder, MD, MSc^{1,2}

¹Department of Obstetrics, Gynecology, and Reproductive Sciences, University of Pittsburgh, Pittsburgh, PA

²Department of Obstetrics and Gynecology, Washington University, St. Louis, MO

³Department of Obstetrics and Gynecology, Kaiser Permanente West Los Angeles, Los Angeles, CA

⁴Department of Obstetrics and Gynecology, University of Arkansas for Medical Sciences, Little Rock, AR

⁵UPMC Center for High-Value Health Care, Pittsburgh, PA

Abstract

Objectives—We aimed to qualitatively describe the emotional burden experienced by women seeking treatment for prolapse. We hypothesized that the condition of prolapse would have an impact on women’s emotional well-being.

Methods—Women with Stage II symptomatic prolapse participated in focus groups or individual phone interviews. A trained facilitator conducted semi-structured focus groups and interviews. These were audio-taped and transcribed. Two authors coded transcripts and identified themes utilizing an “editing” approach. The codebook was amended until no new major themes emerged from the data.

Results—Forty-four women participated: 25 in focus groups and 19 in phone interviews. Mean age of women was 60±10 years and mean prolapse leading edge was 3 (±2) cm. Analysis revealed three main themes: 1) emotions associated with the condition of prolapse (minimal emotions, annoyance, irritation, frustration, anger, sadness, anxiety, depression), 2) communicating emotions related to prolapse (to friends, family, healthcare providers), and 3) emotions relating to treatment (both positive and negative effects).

Conclusions—Prolapse significantly impacts women’s emotional health and subjective well-being. An improved understanding of women’s emotional experiences of prolapse may help providers better meet patients’ needs.

Corresponding Author: Chiara Ghetti, MD, MS, Associate Professor, Obstetrics and Gynecology, Division of Female Pelvic Medicine and Reconstructive Surgery, Washington University School of Medicine in St. Louis, 660 S. Euclid Ave, Maternity Bldg. 2nd Floor, Campus Box 8064, St. Louis, MO 63110, United States, Phone: +1.314.747.1402 | Fax: +1.314.362.3328, ghettic@wudosis.wustl.edu.

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Keywords

Emotions; pelvic organ prolapse; psychosocial; qualitative study; well-being

Introduction

Thirty percent of women are estimated to have symptomatic pelvic organ prolapse (POP).[1] Symptoms of pelvic floor disorders affect many aspects of a woman's life, including social, psychological, occupational, domestic, physical, and sexual domains.[2, 3] It is generally assumed that pelvic floor disorders have an emotional impact on women, and to varying degrees providers who care for women with pelvic floor disorders may have clinical and anecdotal understanding of the effects of pelvic floor disorders on women. The impact of pelvic floor disorders on women's lives and quality of life have been successfully described through the development of condition-specific health-related quality of life (HRQOL) instruments [2, 4]. However, our understanding of women's perceptions and experience of POP is also limited by these instruments which do not capture the complexity of women's experience and do not allow us to discern the impact of these conditions on a woman's emotions and emotional well-being.

Subjective well-being includes emotional and cognitive components, encompassing individuals' emotional reactions, moods, and satisfaction.[5] Lowder et al qualitatively described the impact of prolapse on a woman's body image and her personal relationships, work, and other daily activities. [6] Extensive quantitative literature reports the association between depression and urinary incontinence, but very little is known about the association of mood symptoms with POP. [7] In addition, very little qualitative literature exists characterizing the effect of pelvic floor disorders on women's emotional well-being. An improved understanding of the subjective emotional experience of women with pelvic organ prolapse may help individual women better understand their own experience of the disorder and can help providers more easily recognize and address the social and psychological issues associated with pelvic floor disorders. This study was a planned exploratory and qualitative arm of a large prospective study investigating the prevalence of depression and anxiety symptoms in women presenting for care for prolapse. The objective of the current study was to understand women's emotional experience of pelvic organ prolapse through narratives from women seeking care for prolapse as a primary complaint and to qualitatively describe the emotional burden experienced by these women.

Materials and Methods

Study Sample

The University of Pittsburgh Institutional Review Board approved this study, and participants signed informed consent at time of enrollment. Subjects were recruited from women seeking care at the Women's Center for Bladder and Pelvic Health at University of Pittsburgh Medical Center Magee-Womens Hospital to participate in the parent study. All English speaking women recruited to the parent study were offered participation in the qualitative portion.

Parent Study

All new patients to the Women's Center for Bladder and Pelvic Health who respond "yes" to one or both of the following two questions from the Pelvic Floor Distress Inventory [4]: a) "Do you usually have a sensation of bulging or protrusion from the vaginal area?" and b) "Do you usually have a bulge or something falling out that you can see or feel in the vaginal area?" in their new patient intake form AND demonstrated prolapse stage II by pelvic organ prolapse quantification (POP-Q) [10] examination at their new patient visit were offered participation in the parent study by the treating physician. After completing the consent process, subjects completed Patient Health Questionnaire (PHQ9) [11] screening either in person or on the phone with the trained research assistant. Women unable to complete the informed consent process, participate in data collection, scoring <20 on the Short Portable Mental Status Questionnaire [12], or women deemed actively suicidal by our screening protocol were excluded. All women enrolled in the parent study completed baseline visit study forms at the time of enrollment. Study forms included demographic, history and physical examination information, and the long versions of the PFDI and Pelvic Floor Impact Questionnaire (PFIQ) measures [4]. Primary outcome analyses for the parent study are in preparation.

Research Design—Qualitative methodology was chosen to capture subjects' intimate emotional experiences and to provide a range of perspectives. Qualitative methodology was used to inform gaps of knowledge and limitations of quantitative measures.[8] Focus groups were initially utilized to promote a more natural conversation among participants and create an environment that may be more suitable for self-disclosure and the identification of themes and patterns.[9] Focus groups are composed of 6–10 participants. They are semi-structured discussions in which a facilitator guides participants to obtain information on the topic of interest. A series of focus groups with different participants are performed until few or no new themes emerge during the conversation.

Focus Groups and Individual Interviews

At time of enrollment, all women enrolled in the parent study were asked to indicate their interest in being contacted to participate in one semi-structured focus group. To maximize the chance of capturing the variety of emotional experiences related to pelvic floor disorders and to stimulate as much discussion as possible, subjects were invited to participate in a single focus group at any point throughout their participation in the parent study. Subjects were contacted by telephone to inquire about interest and availability to participate in scheduled focus group sessions. Upon completion of the second focus group, we noted that women with moderate to severe depressive symptoms had not agreed to participate in groups causing underrepresentation of this important population. To maximize the participation of all subjects including those with moderate-severe depressive symptoms, we began offering participation in an individual interview conducted by telephone as an alternative to focus group participation. Individual interviews provided an option for women who might not have felt comfortable in a group setting or those who could not participate due to logistical/scheduling issues.

All focus groups were conducted in a private, closed room in a restaurant near the main office of the Center. Focus group participants included consented subjects, the group facilitator, and a note-taker. Lunch or dinner was provided for all participants. The focus groups and phone interviews were conducted by a female facilitator (CN) with training in qualitative research methodology and extensive experience conducting focus groups on a variety of topics with diverse populations. The facilitator used an interview guide created by the study team to explain study details and to guide discussions about prolapse and emotional well-being using open-ended questions to help stimulate discussion. (See appendix). Additional probing questions were utilized as needed to obtain supplementary information. An experienced female research coordinator with prior focus group experience served as a note-taker during each of the discussions and recorded general comments and non-verbal communication. Each focus group discussion was audio-recorded and transcribed verbatim with the exception of any names or other identifying information.

Individual interviews were arranged in advance at a time convenient to the participant. Only the participant and the facilitator were on the call, and interviews averaged 15 minutes in length (ranging from 6–29 minutes). The same focus group script and probing technique was used during the individual interviews to ensure consistency across both methods of data collection. The interviews were audio-recorded and transcribed verbatim with the exception of any names or other identifying information.

Focus Group and Individual Interview Analysis

An editing approach was utilized to guide the qualitative data analysis. [13] Developed by Crabtree and Miller, the editing approach allows for systematic interpretation of meaningful text passages. Here themes are sorted into categories or codes and then the generated themes are exemplified through representative quotations during the final thematic analysis. To begin, coders read all transcribed texts. From this step a codebook was developed using both focus group and interview data with new codes being incorporated as new themes arose. After the codebook was finalized, two coders coded both the focus group and the interview transcripts independently to ensure inter-coder reliability. Discrepancies were resolved through discussion with a third coder adjudicating any differences between the two primary coders in order to ensure reliability of the coding scheme. Major themes that pertain to the emotional experience of having pelvic organ prolapse are described below.

Other Study Measures

The POP-Q examination was used to assess prolapse and determine baseline stage. The POP-Q scoring system is a standardized method of assessing site-specific pelvic floor defects through nine measurements of the vagina and perineum obtained during a routine pelvic exam.[10] All examinations were performed by physicians trained in the POP-Q examination. The Personal Health Questionnaire-9 (PHQ-9) was used to measure depressive symptoms and is a 9 item self-report scale which correlates highly with the Structured Clinical Interview for DSM-IV. The PHQ-9 assesses how often symptoms have been bothersome over the previous 2 weeks, using a 4-point Likert scale, with higher scores indicating more severe depressive symptoms. Moderate to severe depressive symptoms are defined by score ≥ 10 . The PHQ-9 has been validated for use in primary care and obstetrics-

gynecology outpatient clinics and provides the diagnosis of major depressive disorder and other depressive disorders.[11]

Results

Four hundred and seven women enrolled in the parent study. Of these, one was excluded for suicidality. Forty-four women chose to enroll and complete the qualitative arm. Subjects who chose to enroll in the qualitative arm were representative of the parent study subjects in age and median POP-Q stage. (Table 1)

Twenty-four women completed five focus groups, ranging from 4 to 6 participants per group. Focus group length averaged 50 minutes. Nineteen individual phone interviews were completed. All subjects contributed during the focus group or interview sessions. Eighteen of the focus group participants were postoperative from surgical treatment, 2 were awaiting surgery, and 4 had elected conservative treatment. Of the women participating in the phone interviews, 10 were post-operative, 2 were awaiting treatment and 5 had elected conservative management. Post-operative participants were a median of 1 year from surgery (range 3–21 months). The second method of data collection, the phone interviews, provided a more private exploration of the effects of prolapse on the participant's well-being. All of the women participating in the focus groups had PHQ-9 scores < 10, while 11 (65%) of the women who completed the phone interviews had PHQ-9 scores > 10.

Transcript analysis revealed three main themes related to women's emotional experiences: 1) emotions associated with the condition of prolapse, 2) communicating emotions related to prolapse, and 3) emotions relating to treatment. Each of these main themes was further broken down into sub-themes shown in Table 3. Illustrative examples are provided with participant responses designated in italics.

Emotions Women Experience Associated with the Condition of Prolapse

Little to no emotions related to prolapse were described by some subjects. Their experiences were mainly limited to physical bother. In this group there were subjects whose prolapse had developed so quickly there experienced no emotion, while for others the prolapse had been such a longstanding problem it had just become normal part of life. Overall, the remainder of subjects collectively described a spectrum of feelings related to prolapse. Annoyance, frustration, and irritation were common themes with one woman stating she was frustrated with having new worries. Others described unhappiness associated with the uncertainty of what was occurring and anger that this was happening to them.

Stronger emotions of depression, anxiety, and sadness were described by some. Feelings of anxiety were often associated with a feeling of uncertainty of "something being wrong". Several subjects also described concern and anxiety for the fear of having cancer. Others described anxiety about the change in their day to day routine because of the condition. This was often related to the incontinence symptoms they experienced.

Feelings of sadness were often associated with the thought of getting older. For others the sense of sadness was linked to a feeling of falling apart. Some women further elaborated on

the feeling of falling apart, as a sense of brokenness or defectiveness, but did not directly associate it with a specific emotion. The feeling of brokenness and incompleteness surfaced also in a discussion of how prolapse affected the participant's intimate relationships and how this made her feel. In a similar fashion, some described feelings of not being a whole woman.

Communicating Emotions Related to Prolapse

Overall women described a general difficulty in discussing their pelvic floor symptoms and their effects on daily life. Alongside identifying pelvic floor disorders as taboo, some women identified a sense of shame that made talking about their symptoms even more challenging. Women described secrecy surrounding pelvic floor disorders even amongst other women.

When asked specifically about talking to their gynecologist or surgeon about their emotions, several subjects stated they had indeed spoken to their physician about their feelings. Of the subjects who had already addressed their emotions, one stated that her surgeon brought up the discussion; the other stated she started crying during her visit and her surgeon helped address her emotions. Other subjects were divided about whether to speak to their specialist about their emotions or not.

Others felt it was not a good idea to speak about emotions or mental health issues with a surgeon or physician. Some themes emerged about the responsibility of both patient and physician in discussing topics related to emotional well-being, with some having no expectation that a surgeon would discuss her well-being. In contraposition, others felt that physicians somehow just know how their patients feel.

Emotions Related to Treatment

Themes regarding emotions and treatment were divided into two main subgroups: the effect of emotions on seeking treatment and the effect of treatment on emotions. Negative emotions toward prolapse were seen as both motivating and as hindering in relation to seeking treatment. Feelings of sadness and depressed for some were transformed into motivation when learning something could be done. While for others these negative emotions actually helped them have a more positive outlook.

Negative emotions caused some subjects to be less proactive about seeking treatment for prolapse. Feelings of depression and anxiety were fundamental reasons they did not seek treatment. But for some, this relationship to lack of treatment was interrelated to their own lack of understanding of the condition and thinking this was a part of aging to just accept.

Positive emotional improvement after surgery or treatment was described by some subjects. Others continued to struggle with some negative emotions after treatment. Women described emotional improvement and sense of hopefulness associated with having had surgery.

Some continued to struggle with negative emotions after treatment feeling their hopes were not realized. The themes these women expressed fell into three subgroups: emotions related to persistent symptoms after surgery, fear of recurrence, and post-operative recovery. Some

women continued experiencing pelvic floor symptoms or urine leakage after surgery and found this distressing. Other women had complete resolution of symptoms but feared recurrence of their prolapse. Other women described the emotional challenges of undergoing surgery and the immediate post-operative period. Other women described the interrelated relationship of depression and anxiety affecting the healing process, while simultaneously the immediate post-operative state impacted mental health.

Because subjects with higher PHQ-9 scores did not elect to participate in the focus groups, we used two different research methods (focus groups and phone interviews) to obtain data. Both formats were effective in exploring these topics and provided similar themes. Those participating in the phone interviews at times appeared slightly more forthright in disclosing information about strong emotions related to prolapse such as depression, anxiety, hopelessness, while focus group participants seemed to dwell longer on the annoyance and frustration of the physical symptoms. Our data does not allow us to draw conclusions about this observation. In addition, in discussing their experiences, participants often didn't differentiate between prolapse and other pelvic floor symptoms.

Discussion

The impact of pelvic floor disorders on women is complex and affects many aspects of life. Though studies using condition-specific quality of life measures have given us quantitative information about the impact of pelvic floor symptoms on quality of life, we know very little about the emotional impact of pelvic floor symptoms. This study expands our understanding of women's experience of pelvic floor disorders by both confirming the suspected emotional impact of pelvic floor disorders and also demonstrating the breadth of emotions women may experience in response to their pelvic floor disorders. An important finding of this study is that women's psychological well-being is intimately related with their pelvic floor symptoms. This study highlights that women experience a broad set of emotions associated with the condition of prolapse including feelings of being alone, isolated, broken, defective and ashamed. This study also helps confirm that women find discussing their symptoms difficult. In a study assessing the impact of pelvic floor disorders on body image, Lowder et al. identified similar themes.[6] In both studies, focus groups were extremely effective techniques in studying sensitive topics such as the impact of pelvic floor disorders on women's lives.

The use of qualitative methods to explore the relationships between pelvic organ prolapse and a woman's emotional well-being is the main strength of this study. This study was a planned exploratory analysis of a quantitative parent study investigating depression and anxiety symptoms in women with prolapse. Focus groups allow women to describe their own personal experiences and in doing so provide narratives of their personal struggles that cannot be gleaned through questionnaires and assessment of mood symptoms alone. Qualitative methodology also allows for exploration of complex interrelationships through rich description that can often be lost with structured surveys. The use of individual phone interviews in addition to focus groups further strengthened this study. Our study found that women with more severe depressive symptoms were more likely to agree to participate in phone interviews than focus groups. Individual phone interviews allowed us decrease

selection bias and to expand the participant pool and include the opinions of women who did not feel comfortable with group discussion and/or had more severe depressive symptoms. Kaplowitz studied the topics discussed in focus groups versus individual interviews and found that interviews were more likely to address socially sensitive discussion topics when compared to focus groups.[14] While our data does not allow us to draw conclusions as to the variation in topics discussed in the phone interviews versus focus groups, inclusion of individual phone interviews may be an important consideration in the study design of future qualitative studies in our field; particularly for individuals with depression. In our study, the data obtained from both methods was rich with detail about prolapse and emotional well-being. An additional strength of this study was the inclusion of subjects in various stages of the treatment process and who had chosen both conservative and surgical management. This allowed us to explore the full range of experiences that could be expected for patients undergoing management of symptomatic prolapse.

The qualitative approach employed, however, also has its limitations. By nature it may lack generalizability to larger more ethnically diverse populations. In this study, our results may be generalizable to Caucasian women visiting an urban, tertiary academic medical center. Generalizability is not the intent of qualitative research rather, it provides us more information for broader base investigation.[6] Our study design formally assessed the condition of prolapse and did not ask specific questions about the contributions of urinary incontinence and fecal incontinence to emotional well-being. However, participants often did not differentiate between pelvic organ prolapse and their other pelvic floor symptoms, specifically urinary incontinence, when describing their experiences. Additionally, our study participants were women seeking care for prolapse and had often experienced prolapse symptoms for several years. Our findings may not be generalizable to all women with prolapse. This study does not examine the longitudinal evolution of the emotional experiences over time, over the progression of prolapse symptoms, or following treatment. Many participants had been treated surgically, and their responses pertaining to the time before surgery may have been affected by recall bias. An additional limitation of our study may be the focus on depressive and anxiety symptoms in our interview guide. We understand that women experience a wide array of emotions, and many emotional experiences were elicited. The focus on depressive and anxiety symptoms in the interview guide may have biased responses. Depressive and anxiety symptoms were used as a starting place for discussion due to the larger implications of these conditions.

This research study begins a much-needed exploration of the impact of pelvic organ prolapse on emotional health. Additional research is needed to better understand the full implications of pelvic floor disorders on women's overall well-being and on emotional health, as well as the impact of well-being on care seeking. Future studies should focus on examining the temporal progression of women's emotional experience with prolapse and prolapse treatment. A better understanding of the emotional burden of pelvic floor disorders may help providers better understand patients' needs and expectations and provide individualized care. A woman's emotional and subjective experience is the backdrop upon which she will seek treatment and experience its effects. This subjective experience may directly impact her care choices, postoperative course, satisfaction with treatment, and treatment outcomes. A person's overall subjective well-being is intimately related to

emotional well-being. In turn, the relationship between emotional and physical health is an ancient concept, dating back to Hippocrates who linked emotional factors and disease processes. Contemporary studies suggest that emotional states may influence physical health; likewise physical health may influence emotional states.[15] This study suggests that women's emotions strongly impact their willingness to discuss and seek care for prolapse and their emotions impact their treatment choices and recovery. Together these have significant public health implications.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Appendix: Focus group/Interview interview guide

Scripted introduction

Opening Questions

1. Tell me about when you first noticed your prolapse?
2. Tell me about your experiences with having prolapse?
 - a. In what ways has it affected you the most?
3. What emotions have you experienced related to prolapse?
 - a. Have you experienced anger, frustration, sadness, anxiety?

Main Questions

4. Before you had the prolapse, did you ever have periods of time when you were “down”, depressed, or anxious?
 - a. Were you ever treated for any of these feelings?
 - b. If you were treated, what types of treatment did you have?
5. Are there aspects of prolapse that make you feel “down”, depressed, or anxious? (Were there aspects of prolapsed that make you feel “down”, depressed, or anxious?)
 - a. What is it about prolapse that you believe causes these emotions?
 - b. How have these feelings affected the way you think about the prolapse?
 - c. Have these feelings affected the way you deal with prolapse?
 - d. Do you feel these feelings have affected your choice to seek care for prolapse or your choice of surgery?
 - e. Have you talked to anyone else about these feelings? If so, who?
6. How did having surgery affect the way that you feel emotionally?
 - a. Did it change your feelings of being down, depressed, or anxious?
 - b. What was the hardest part about having surgery?

- i. What was the hardest part, emotionally?
- c. Do you feel that feelings of being “down”, depressed, or anxious affected how you recovered or dealt with having surgery?

Closing Questions

- 7. Did you/would you feel comfortable talking to your gynecologist or surgeon about your feelings?

Table 1

Focus group and phone interview participant characteristics

Participant Characteristics	All (n=44)	Focus groups (n=25)	Individual Interviews (n=19)	p-value
Race: Caucasian, n (%)	39 (89%)	22 (88%)	17 (89%)	0.50
Mean age in years $\pm$ SD	60 $\pm$ 10	60(10)	61(10)	0.90
Mean BMI kg/m ² $\pm$ SD	29 $\pm$ 6	27(3)	31(8)	0.06
Marital status: Married, n (%)	27 (61%)	16 (61%)	11 (58%)	0.64
Smoking: Never-smoker, n (%)	29 (67%)	19 (79%)	10 (52%)	0.05
Menopausal status: Post-menopausal, n (%)	36 (82%)	21 (84%)	15 (79%)	0.46
Mean leading edge prolapse in cm $\pm$ SD	3 $\pm$ 2	3(2)	3(2)	0.29
Mean years with symptoms $\pm$ SD	3.8 $\pm$ 5.5	4.9(6.3)	2.5(2.8)	0.48
Nocturia- moderate/severe [√] , n (%)	19 (34%)	8 (32%)	11 (58%)	0.16
Mean number of medical comorbidities $\pm$ SD	6 $\pm$ 5	5(5)	7(4)	0.08
Mean number of medications $\pm$ SD	7 $\pm$ 5	6(3)	8(6)	0.97
Mean Social Problem Questionnaire $\pm$ SD	1.0 $\pm$ 1.4	0.68(1)	1.32(1.6)	0.30
Median UDI (IQR)	190 (151–246)	175 (150–233)	223 (155–273)	0.17
Median POPDI (IQR)	172 (115–230)	133 (100–222)	196 (150–244)	0.14
Median CRADI(IQR)	192 (125–242)	179 (100–218)	206 (150–275)	0.09
Median PHQ9 score (IQR)	6 (2–11)	3(1–5)	10 (6–16)	0.001

[√] defined as having answered, “moderate or severe” to question 27 of the PFDI, “Do you usually awaken during your normal sleeping to urinate?”

Table 2

Main themes and subthemes

<p>1. Emotions Women Experience Associated with the Condition of Prolapse</p> <p>a. Minimal emotions</p> <ul style="list-style-type: none"> i. “It was just a physical annoyance that I wanted fixed.” ii. “No, actually... it happened really fast ...I was at work one day ... and I was lifting, .. I felt it when it happened...and he told me that I had prolapse.” iii. “To tell you the truth, I just forgot about it, it just became my life iv. “The prolapse really didn’t affect me at all...I felt differently at first, but once I got used to the idea I was OK.” <p>b. Annoyance, irritation, frustration, anger</p> <ul style="list-style-type: none"> i. “Just annoyance with the whole thing.” ii. “... it’s frustrating knowing that if I’m going to go somewhere then I have to worry about what are the seats going to be like where I’m sitting, how am I going to dress.” iii. “Just unhappy because I wasn’t sure what was going on.” iv. “Anger, yeah, with me it was anger...It shouldn’t have happened to me.” <p>c. Anxiety, sadness, depression</p> <ul style="list-style-type: none"> i. “I guess it was anxiety ... thinking something was wrong ... that’s why I went to get it checked out.” ii. “I’d be anxious...do I have uterine cancer? I was scared, because a lot of my friends had little touches with different kinds of cancers and I haven’t had anything ... but there is something down there that’s not right.” iii. “Anxiety...I have to make sure I have the equipment, the pads, the different things, because I have to wear one to work in case I sneeze or cough” iv. “I think I did feel sad, well my stuff is just falling out, and I’m getting older but there’s so many things I want to do...so as I said yes, sadness.” v. “I guess sadness because I’m thinking, oh I’m old, and I’m falling apart.” <p>d. Broken and defective</p> <ul style="list-style-type: none"> i. “ I just remember feeling, I don’t know what emotion this would be, but you just feel like you’re broken. As if you have a house and you need to repair whatever’s broken.” ii. “I was basically told by the doctor that I had this prolapse. Once I was told that, I felt differently about my body, I felt like I was broken.” iii. “You feel like you have a defect or something, you’re defective.” iv. “your relationship with your husband ... is a problem with the prolapse... and then you have the problems that you had to have your ovaries and uterus out ... you start to think you’re not really a full woman, and that bothers me...the joke is will St. Peter let me in without all my parts? But still, you know, the jokes, cover-up some insecurities.” 	<p>2. Communicating Emotions Related to Prolapse</p> <p>a. Difficulty communicating with friends/family</p> <ul style="list-style-type: none"> i. “It’s very hard to explain to people most of the time...., even to my husband,...it’s just a very difficult thing. Most people don’t want to hear about it actually...I hate to say it’s sort of a taboo subject.” ii. “For me it’s sort of sad to even admit, but it’s maybe another emotion...it is the shame. I would hardly talk to anyone about it...you don’t want to talk to someone who doesn’t know about it or understand. It’s like, you’re ashamed to talk about it.” iii. “I have a women’s support group from church... it’s amazing because nobody wants to talk about it, but when somebody does bring something up then...everybody, it seemed like, had something related to that problem...I really think it’s the best kept secret in women for such a long time.” <p>b. Communicating with healthcare providers</p> <ul style="list-style-type: none"> i. “I don’t have a problem with that because that affects your physical well-being too.” ii. “I think they should, I mean it’s part of your overall health so they really should have some idea what’s going on with your emotional aspects also.”
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iii. "I think they should be aware of your mental state, and I think they should know if something is not sitting right with you."

c. Not communicating with healthcare providers

i. "They're always in a hurry...they're always certainly on this fast track."

ii. "I think it's a two-way street. I think the patient needs to be assertive and do her part. They can't do everything "

iii. "Probably I would talk to the doctor, but almost more for a referral ... I think that they do the science part of it, the surgery part of it ...rather than holding your hand because you're feeling down.

iv. "I think that they probably know, unless somebody's really good at hiding how they feel."

3. Communicating Emotions Related to Treatment

a. The positive effect of emotions on seeking treatment

i. "when I found out that it could be fixed, I thought let's go for it...I don't want to be sad and depressed, I would rather be happier."

ii. "I really made a conscious effort to be very positive, to have my spirits up ... I was moving forward."

b. The negative effect of emotions on seeking treatment

i. "I think it's what led me to accept if for as long as I did without treatment. I figured it was inevitable."

ii. "*I didn't know anything could be really done about it and I thought, this is just what happens to old ladies.*"

c. The positive effect of treatment on emotions

i. "Oh yeah, I felt less sad, less depressed." Another woman stated, "After my surgery I feel much better, much, much, better. I don't have to worry about having sex with my husband...I don't have to worry about taking walks and having it [prolapse] come out."

ii. "it [the surgery] made me feel more assured... more hopeful that there was something good that was gonna come out of it."

iii. "I had that sense of hope that, it's done...I'm headed in the right direction."

d. The negative effect of treatment on emotions

i. Persistent symptoms

1. "I was not expecting the total quick fix but expecting a little bit more than what I've gotten so far... I have more hopelessness that this is ever going to get fixed."

2. "I think it's a little depressing after [surgery] when you still have problems."

3. "I thought this was going to solve all of my problems. But now, as time goes on, and I realize it didn't really solve my bladder issue."

ii. Fear of recurrence

1. "I felt better that I'm pretty much back to normal. But I'm just an overly nervous person, so I have this fear that it's going to happen again; I have a little black cloud hanging over my head but I try not to think about it."

iii. Post-operative recovery

1. "After the surgery I was crying constantly...everything was setting me off. Every little thing would bother me and I would just start crying... I just wanted to be by myself because, it was as if I were wounded, I just wanted to be by myself."

2. "It [depression and anxiety] kept me from being active, and being able to heal...the healing process takes a while, but it keeps me from being out in the world trying to get over my depression and things like that. That holds me back, it keeps me at home."