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Factors Influencing Young Women's Preparedness for Their First Pelvic Examination

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Abstract

Objectives—To understand factors contributing to women's level of preparedness for their first pelvic examination.

Methods—We conducted semi-structured interviews with young women, aged 18–24 years, who had received at least one pelvic examination. This analysis explored: 1) gynecologic and health care experience prior to the first pelvic examination; 2) pre-procedure expectations and concerns; and 3) pre-procedure knowledge about the examination. Interviews were transcribed and computer-assisted content analysis was performed; salient themes are presented.

Results—Thirty women completed interviews. Thirteen women described feeling poorly prepared for their first pelvic examination and 17 women described feeling prepared for the examination. Factors influencing women's level of preparedness for their first pelvic examination included: 1) age at first examination, 2) pre-examination knowledge of the examination; 3) medical trust or mistrust; 4) overall comfort with one's body; and 5) prior sexual experiences and trauma.

Conclusions—Preparedness for the first pelvic examination emerges as a subjective concept shaped and determined by the interplay of many factors. While some factors, such as age and personal sexual and reproductive health history, may not be modifiable by clinical practice, other factors, including information that young women receive prior to experiencing their first pelvic examination, may be modifiable by clinical practice.

Introduction

The first pelvic examination presents an opportunity to evaluate a young woman's reproductive health status and provide important guidance and education. This examination is an important component of care for many young women, as adolescents and young adults are at an increased risk for sexually transmitted infections, unplanned pregnancy, and other

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gynecologic complaints (1–3). However, this examination also has the potential to cause anxiety and negatively impact young women’s future engagement in health care (4–6).

The timing and indications for the first pelvic examination have evolved over recent years. Professional guidelines have delayed the timing of the first Pap smear from 18 to 21 years, obviating the need for a routine pelvic examination before the age of 21 (7). Additionally, the American College of Obstetricians and Gynecologists (ACOG) recommends the first gynecologic visit take place between 13 and 15 years to establish a relationship with a reproductive health care provider before the first pelvic examination (8). According to these guidelines, pelvic examinations are not recommended for adolescents under 21 years unless there is a clinical indication (7,8).

Understanding how young women perceive the first pelvic examination is important to enable providers to optimally educate and prepare adolescents and young adults for this important and potentially intimidating examination. However, there is a paucity of research regarding perspectives of the first pelvic examination. Much of the existing literature was conducted in Europe more than a decade ago (4–6,9–11). Therefore, we conducted a qualitative study to explore factors contributing to women’s preparedness for their first pelvic examination (12).

Materials and Methods

We recruited women from the University of Chicago campus and surrounding communities between August 2016 and May 2017 using a variety of recruitment strategies, including social media, outreach to student organizations, and study flyers. Potential participants were invited to contact the study team via email or phone. A study team member contacted women to screen for eligibility and sampling criteria. Inclusion criteria included age 18 years and 24 years, having had a previous pelvic examination, and ability to provide consent in English. We used purposive sampling to invite eligible women to participate in interviews, asking participants questions regarding their age, race and ethnicity, education status, indication for the examination, and location of the examination. This information was used to create a sampling matrix to ensure that we had representation from all of the predetermined sampling categories. Additional outreach efforts were made to recruit participants with lower representation (younger women and women who lacked a college degree), primarily through posting flyers in additional locations in communities surrounding the University of Chicago. While we determined an *a priori* sample size of 30 participants based on prior experience with qualitative research and according to standard text on qualitative methodology, recruitment continued until reaching thematic saturation—the point at which no new information was to be gained from further data collection (12, 13). Women were compensated \$25 for their time. The study was approved by the University of Chicago Institutional Review Board.

After providing oral consent, women completed a short survey assessing demographic and reproductive health data prior to participating in a semi-structured interview (Appendix 1, available online at <http://links.lww.com/xxx>). This analysis focuses on: (1) gynecologic and health care experience prior to the first pelvic examination, (2) pre-procedure expectations

and concerns, and (3) pre-procedure knowledge about the examination. Interviews were audio recorded and transcribed by the first author.

Using principles of grounded theory, we used an inductive process, such that the data generated by our research questions shaped the framework used to analyze the interviews (12). Specifically, we began with multiple reviews of the interview text and generated our framework (code directory) from the data. We further refined our code directory through iterative comparisons of interviews independently coded by both authors. We reconciled codes with an inter-rater reliability Kappa score of 0.7 and used the final directory to code our interviews using ATLAS.ti (Version 7.8.15, Berlin). Study team members reviewed the transcribed interviews, grouped segments of text thematically, and used ATLAS.ti (Version 7.8.15, Berlin) qualitative software to apply corresponding codes from the directory to the text. The study team subsequently met to discuss and interpret key findings and resolve disagreement. Study team members reviewed segments of text that contained differences regarding code application and reconciled differences between codes in order to arrive at mutually agreed upon code applications. We identified major themes and constructed graphical models of relations between themes grounded in the narrative data [Figure 1]. This analysis presents salient themes regarding pre-examination factors influencing whether or not participants felt prepared for their first pelvic examination.

Results

Fifty-five individuals responded to our recruitment strategies. Thirty-six individuals were reached by phone to be screened and thirty women completed an interview. Participant demographics are presented in Table 1. Overall, 13 women described feeling ill-prepared and 17 women described feeling prepared for their first pelvic examination (Table 2). Factors influencing women's level of preparedness for their first pelvic examination included: age at first examination, pre-examination knowledge, medical trust and mistrust, comfort with one's body, and prior sexual experiences and trauma.

Nearly one third of participants identified that their age at the time of their first examination influenced their level of preparedness and outlook on having their first pelvic examination. Of note, participants who experienced their first examination at similar ages provided heterogeneous descriptions of how their age affected their experience. The average age of participants who described feeling prepared for the examination was similar to those who felt unprepared (19.6 years and 19.7 years, respectively). One participant who obtained her examination for heavy menstrual bleeding and as follow-up after a ruptured ovarian cyst cited that her age at the time of the examination (19 years) was central to feeling ill-prepared. She explained,

Because at the time when I had my pelvic examination, I was nearing the end of my first year of college so there was still a lot that—and there is still a lot that—I didn't know...

Another participant cited that waiting until age 18 to receive an examination was fundamental to feeling prepared. This participant who obtained her examination for vaginal

pain felt that age 18 was a relatively older age at which to receive her first pelvic examination. She described,

Oh *yeah*. I mean, by that time I was already starting to pay [for] a few things by myself, I was in my own dorm room, I was in my own space. I was like making meals for myself. So going to the doctor by myself was just another extension of being an adult.... So part of being *so old* by the time I got to it was that, like, it was just another experience of being a full-grown adult that you don't really anticipate.

No single chronological age emerged as a natural cut-off between those who described feeling prepared versus those who described feeling unprepared for their first examination. Rather, participants described a sense that they were in a phase of life where it was either appropriate or inappropriate to receive such health care.

Prior to experiencing the examination, participants' knowledge about the pelvic examination varied widely in amount, quality, and source. Participants described sources ranging from first-hand accounts from friends and relatives to YouTube informational videos. Nearly half (14/30) of participants reported receiving little to no information prior to obtaining their first pelvic examination. Three participants indicated during their interview that they were still unclear about what constituted a "pelvic exam," despite having received at least one during their lifetime. The distinction between a pelvic examination and a Pap test, for example, was a common source of confusion.

Obtaining information about the examination experience was challenging, as one participant who sought care for a yeast infection described:

I don't think I had heard anything about it [the pelvic exam]. I don't think I had a conversation with *anyone*. 'Cause I didn't know—none of my friends had had one—that I knew of I guess. And it was definitely not something I talked with my mom about, then. Yeah, so I wouldn't have heard it from anyone.

Having inadequate information contributed significantly to women's sense of feeling unprepared prior to their first pelvic examination. One participant explained:

I think I would have been a lot more confident [with more information]...Whereas I went in with the idea that whatever happens to me happens to me, as opposed to like if I had any sort of formal training at all about what a pelvic exam was. First of all I would have known it was happening to me and I would have been able to, like, figure out all the steps and everything as they were happening to me and have labels. And that kind of information would have been nice.

This sentiment was echoed in many interviews: having accurate and adequate information prior to the examination would have given participants a sense of ownership and control over the process, allowing them to feel better prepared for the examination.

Over one third (12/30) of women wished they had received information about the examination from a health care provider with whom they had had a pre-existing relationship. Participants regretted that their pediatricians, primary care doctors, or gynecologists seen for birth control had not discussed the timing and indications for initiating gynecologic care,

described the nature of the pelvic examination, or helped them establish care with a women's health provider. One participant who obtained her first examination during a routine visit explained:

I think speaking to a pediatrician about getting—transitioning into starting gynecologic care would have been helpful in knowing why the pelvic exam was done, why it's done so—like how often it should be done and what that has, or like what it's looking for or how that could help maintain your health moving forward.

Interviewees believed that obtaining such information from a trusted health care provider would have resulted in higher quality information, and that their relationship with these providers would have palliated some of the anxiety about the examination.

Participants who reported receiving adequate information about the examination explained that this knowledge helped them prepare for the experience. They identified that the most helpful information included when one should seek out gynecologic care, information about the steps of the examination, and if the examination would be painful and uncomfortable. One participant who had received extensive information from her mother stated that her experience with her first examination, obtained for vaginal pain, “was probably way better than someone who has no idea.” She reflected that she was “very prepared for what it would be like.” Another participant who obtained her examination after becoming sexually active described a helpful prior visit to student health:

I went—in college I went to the health center and was like, “Hey can I come in and like, get an exam?” And they were like, “You don't need one but like we can talk about it.” Which was helpful. She, like, showed me on the diagram, like, what they would have done. And I was like, oh, I had no idea, like at all. So that was helpful when I did go for the first time I was like, okay I have a sense of what is going to happen and the doctor that I went to was actually really great.

Ultimately, no participant described feeling “too prepared”—uniformly, participants identified more information as helpful to prepare for their first exam.

Participants' general views of health care substantially contributed to their sense of preparedness to undergo their first pelvic examination. The majority of participants (21/30) reported a positive overall view of health care, while five reported a negative view of health care, and four were equivocal or neutral (Table 2). Factors contributing to whether these women generally trusted health care providers and the larger health care system included family members' orientations towards and prior personal experiences with health care. Participants who had an overall positive orientation to health care also reported a positive or benign opinion of receiving a pelvic examination, while those who had a negative orientation to health care had more negative pre-examination thoughts and feelings about receiving the examination.

Women's negative orientations towards medicine ranged from dislike to distrust. As one participant who obtained her examination during a routine visit described:

Our insurance changed a lot over the course of me growing up, so I never had like one doctor growing up all the way through. Um, I don't really like doctors that much. I don't trust them that much [*laughs*].

For these women, the idea of receiving a pelvic examination was far more unpleasant than their positively-oriented peers. One woman who sought care after becoming sexually active explained that her negative pediatric experiences contributed to her reticence to engage in women's health care, saying:

I think that scared me the most. Because of like, because of how little I trusted them [prior health care providers], and I was like, I was *not* comfortable at all getting a pelvic examination because of how little I trusted them before.

Conversely, participants with health care providers in their families (5/30) described a fundamental trust in the medical system and valued the importance of receiving medical care. One interviewee who obtained her examination during a routine visit explained:

My grandpa is a gynecologist. Well he's a retired gynecologist...I always saw—I guess I would say I saw doctors as like, yeah people who were trustworthy like my grandpa, probably.

Many (10/30) participants with a positive orientation to health care who did not have family members involved in health care explained that their parents taught them to trust and be open and honest with health care providers. Other participants described past health care encounters that laid the groundwork for being more comfortable with having their first pelvic examination. One woman described how early positive health care experiences and positive reinforcement by her mother helped prepare her for her first pelvic examination, which she received when presenting for an IUD insertion:

I think I have faith in the system. So like, I was like, "Okay. These people are trained. They know what they're doing. It's awful but I have to suck it up and deal with it." ... Because it's also—so I had, like, I had gotten like a CAT scan, I had gotten ultrasounds for other issues that I had. So I'd had weird medical things before. So it wasn't like this was my first sort of procedure that was different from the norm. And I think just because my parents, or my mom had set the tone of like, "It's fine. We're going to do it. We need to."

Women's sense of comfort with their bodies had noticeable implications on how prepared they felt for their first examination. Seventeen participants described being comfortable with their bodies prior to the examination, 11 described being uncomfortable, and two were equivocal or neutral. Women who described a comfort with their bodies and with physical intimacy also tended to view the pelvic examination as a benign medical encounter. As one woman who obtained her examination during a routine visit explained,

I'm pretty much comfortable talking to anyone about my body. Like I don't—you know—I don't care, I'm not super shy, I'll like get up in front of—I lead a discussion about sex ed for octogenarians so we're good on that front. So I think just a general "I don't care" attitude.

Others perceived the examination to be an educational and potentially empowering experience. A participant who sought out an examination after becoming sexually active described further,

I think as a feminist and as someone who was raised in a very body-affirming and health care-affirming and sexually-affirming space I think it really helped me to not feel embarrassed or not feel afraid of it.

Nearly one third of participants connected their anxiety or feelings concerning the examination to a discomfort with physical intimacy. One participant explained:

I'm not the kind of person who is like, comfortable with hugs and all of that. So for me to get to a point where I like someone enough—or not even just like, but am okay with them, and okay with them coming into my personal space.

Several of these participants who felt uncomfortable with the intimacy and exposure related to the examination connected their discomfort with their familial and cultural backgrounds. One participant who obtained her examination after experiencing vaginal pain reflected,

I think just like topics of like sex and bodies were taboo, like I think they are in a lot of households. Not because—like my parents didn't think there was anything wrong with it, it just didn't come up. Like I think it was more awkward for them than it was for me. And so we didn't talk about it. So it was uncomfortable to be in a situation where someone was going to be thinking about it.

Another participant explained why she waited until she had left home to seek gynecologic care:

My mom was very specific about me never, um, like, breaking my hymen before marriage or like maintaining my virginity. Like she was very particular about that. Like she wouldn't even let me use tampons...Or like the fact that she definitely believes that a pelvic examination is only something you need to do after you're married because that's when you're going to have sex.

Women who were uncomfortable exposing their bodies emphasized that no provider practice could overcome this pre-existing discomfort with physical intimacy.

Participants' prior sexual experiences or lack-there-of influenced their sense of preparedness for their first pelvic examination in disparate ways. One participant who obtained her examination during a routine visit described a common sentiment among those who received a pelvic examination before sexual debut:

Prior to my first pelvic exam I was not sexually active or anything like that. So for me it was like, okay nothing's even been in there, so I don't want anything in there, like *[laughs]* I have no way of being prepared for what that's going to feel like or what to expect, so I would say a lot of anxiousness, nervousness around that.

However, a few (3/30) women who had not experienced sexual debut before their first examination did not view this lack of experience as having negatively impacted their comfort going into the examination. Participants who received the examination for a painful or acute indication, for example, focused on alleviating pain. Other participants felt the lack

of prior sexual experience contributed positively to their sense of comfort with having the examination due to not having to admit prior sexual activity to a provider, not being worried about a parent discovering such information, and not being concerned that something “wrong” would be discovered on the examination.

Participants who had experienced sexual debut prior to their first pelvic examination also described differing effects of their sexual debut on their preparedness for the examination. Over one third felt that prior intimate contact with a partner was a necessary precondition to feeling prepared for the examination, echoing the sentiment of many (but not all) participants who had their first pelvic examination prior to sexual debut. One participant reflected:

... I think that had that been the first time that anyone other than me was up in that area, it would have been more invasive in a lot of ways. And I think that people who are less open about their sexuality, it might be a thing too—people who are like, “This is my area, my space, and no one’s been up there before.” But having had sex before and being pretty open about it when I was having it, like being about to talk to friends about sex itself, and having had quite a few partners before I had a long-term relationship—I was comfortable with it, but that could definitely be a factor for other people.

Notably, this intimate contact did not have to include penetrative intercourse. For one woman, who identified as lesbian and did not participate in penetrative sex, the knowledge that an intimate partner (and not a physician) was the first person to see and touch her genitals was essential to her comfort. She stated:

I can imagine that for somebody getting a pelvic exam who’s never experienced any sort of intercourse or, like, anybody [laughs] you know, *anything* in their vagina, I think that could be really upsetting. And I didn’t have that experience. I know what that feels like in a very different context and so it wasn’t *scary*...I think it helped to sort of know in some ways going in what it was going to *feel like* at least, you know?

Three participants described how having experienced sexual trauma shaped their comfort with the idea of receiving a pelvic exam. One participant recounted having an initial appointment with a gynecologist at age 19, where no exam occurred, and then a subsequent visit at age 22 with a gynecologist to obtain a pap smear where an exam did occur. She reflected on the significance of this delay in light of her history of sexual assault:

The first time I went to the gynecologist when I was 19, I had just recently retrieved the memories of my assault and so I’m really glad actually that I didn’t have a pelvic exam at that first encounter because, like, 19 to 22 were years of immense reckoning and learning and mourning and just processing these previous experiences I had had that weren’t medical at all, but were very disturbing.

For these women, being allowed to wait for their first pelvic examination until after they had processed their trauma allowed them to be more comfortable.

Discussion

Preparedness for the first pelvic examination emerges from these interviews as a subjective concept shaped and determined by the interplay of many factors, including: age, informational context, relationship to the medical system, comfort with one's body, and sexual history. No single age was associated with an increased sense of preparedness for the first pelvic examination. Instead, women who subjectively perceived that they were mature enough for the examination generally felt more prepared compared to women who perceived that they were subjectively too young for the examination. Other factors appeared to influence young women's preparedness for the first pelvic examination in more consistent ways. Specifically, knowledge about the examination, trust in medical providers, comfort with one's body, and prior sexual debut tended to positively influence women's perceived preparedness for the first pelvic examination.

This study exploring factors contributing to young women's sense of preparedness for their first pelvic examination adds important knowledge to an area of research that is limited in scope. The existing literature exploring adolescent and young adult experiences with the pelvic examination in general is largely from Northern Europe (4–6, 9–11). Therefore, this literature may not be generalizable to the American adolescent and young adult population due to differences in health care practices and attitudes towards sexual and reproductive health. Scant literature focuses exclusively on adolescent and young adult experiences with the first pelvic examination and this existing literature underscores the impact of age. Prior research has demonstrated an association between increasing age and a more positive experience with the first pelvic examination (6). A large survey of women in Denmark assessing factors associated with discomfort during the gynecologic examination found that women who were 18–25 years were more likely to experience discomfort during the examination. Our study was not designed to quantitatively assess the relationship between age and preparedness for the pelvic examination. However, participants subjectively expressed feelings that their age contributed to their sense of preparedness for the examination. This prior study also identified that a history of sexual abuse and poor satisfaction with sexual relations were associated with a discomfort with the pelvic examination – findings that were echoed in the words of this study's participants (6).

Limitations of this study must be recognized. Study participants were primarily from an urban university community and were mostly college-educated. Additionally, more than half of the participants were white. Therefore, the experiences of women represented in this study may not reflect the experiences of women from other education or racial or ethnic backgrounds. Including women with different backgrounds, such as women without a college degree, may have elicited additional themes that were not elicited in the absence of representation from these groups of women. Further, selection bias must be considered. Participants in this study responded to flyers and emails inviting women to discuss their experiences with their first pelvic examination. Some who responded to this invitation, therefore, likely did so in part due to strong negative or positive responses towards their personal experiences with the examination. However, we did elicit myriad perspectives with regard to participants' sense of preparedness for their first pelvic examination and the related influencing factors.

Despite these limitations, this qualitative study helps to generate hypotheses regarding how to improve young women's sense of preparedness prior to their first pelvic examination. Several factors explored in this study, including age at first examination or an individual's personal history of sexual activity or trauma, may not be modifiable by clinical practice or professional guidelines. However, this study emphasizes the importance of health care providers discussing such topics prior to conducting the examination and taking these factors into account when conducting the examination. For example, recommendations exist on how to approach the pelvic examination for women with a history of sexual trauma (14).

Other factors explored in this study may be modifiable through clinical practice or professional guidelines. Most notably, participants stressed the important role that knowledge of the examination or lack-there-of played in their level of preparedness for their first pelvic examination and several participants wished that they had learned about the examination from a trusted health care provider, such as a pediatrician. These findings suggest that efforts are needed to enhance patient-provider communication about the pelvic examination, especially with front-line adolescent providers such as pediatricians. Additionally, referring patients for the first gynecologic visit between the ages of 13–15, as recommended by ACOG, affords the opportunity to form a strong patient-provider relationship and address key reproductive health education topics, including the pelvic examination, in a controlled, less stressful setting. However, this recommendation may not be reflected in practice. Only 23% of obstetrician-gynecologists responding to one national survey believed that girls should initiate gynecologic care between 13 and 15 years (15). Therefore, further outreach and research efforts are warranted to help guide pediatricians, obstetrician-gynecologists, and primary care providers on when and how to optimally address the first pelvic examination with their adolescent and young adult patients.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1.
Graphic representation of key themes.

Table 1**Participant demographics**

	Interview participants N=30
Age of participants, median years (range)	22 (18–24)
Highest education level	
High school	1 (3)
Some college	10 (33)
College	10 (33)
Some graduate school	8 (27)
Graduate school	1 (3)
Ethnicity	
White	17 (57)
Black	3 (10)
Asian	5 (17)
Hispanic or Latina	2 (7)
Multiple ethnicities	2 (7)
Other	1 (3)
Age at first pelvic exam, median years (range)	19 (16–24)
First exam also first women's health care visit?	
Yes	16 (53)
No	14 (47)
Location of first pelvic exam	
Family 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)

Data are n (column%) unless otherwise specified

Table 2

Demographics of participants who reported feeling prepared versus unprepared for their first pelvic exam

	Prepared 17 (56.7%)	Unprepared 13 (43.3%)	p-value
Age at first pelvic exam, median years (range)	19 (16–24)	19 (17–24)	0.82 *
Medical trust vs. mistrust			0.27 **
Trust	14 (82)	7 (54)	
Mistrust	2 (12)	3 (23)	
Neutral	1 (6)	3 (23)	
Comfort with body			0.72 **
Comfortable	11 (65)	6 (46)	
Uncomfortable	5 (29)	6 (46)	
Neutral	1 (6)	1 (8)	
Prior sexual experiences			0.75 **
Pre-coital	6 (35)	4 (31)	
Post-coital ***	10 (59)	7 (54)	
Prior sexual trauma	1 (6)	2 (15)	
Visit acuity			>0.99 **
Routine visit	11 (65)	9 (69)	
Acute concern	6 (35)	4 (31)	

Data are n (column%) unless otherwise specified

* Wilcoxon-Mann-Whitney test

** Fisher's exact test

*** Includes participants who had undergone self-identified sexual debut, but had not engaged in penetrative intercourse (e.g., a female participant who was sexually active solely with women).