CONCLUSION: Women with chronic pelvic pain, with and without a history of sexual trauma, experience trauma due to interacting with the healthcare system. They have clear needs and preferences regarding the delivery of gynecologic care, and have feasible suggestions for improving the clinical environment. Focus groups promoted an environment of healing and community.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Whitney T. Ross: Nothing to disclose; Bethany Snyder: Nothing to disclose; Heather Peyrot-Stuckey: Nothing to disclose; Jennifer McCall-Hosenfeld: Nothing to disclose; Gerald J. Harkins: AbbVie, Honorarium, Speaker; Carly P. Smith: Nothing to disclose.

OBJECTIVES: To explore the experiences of women with chronic pelvic pain, with and without a history of sexual trauma, seeking gynecologic care. This study was conducted in order to understand the barriers to care experienced by women with chronic pelvic pain and describe the needs and preferences related to gynecologic care. This study identified trauma-informed care practices that healthcare providers may use to improve care for women with chronic pelvic pain.

MATERIALS AND METHODS: We conducted a qualitative study consisting of six semi-structured focus groups of women with chronic pelvic pain (n = 22) between fall 2019 and spring 2020. Participants were recruited from a tertiary care ambulatory clinic that serves predominantly women with chronic pelvic pain and endometriosis. Participants were assigned to groups dependent on a positive (n = 4 groups, 13 women) or negative screen (n = 2 groups, 9 women) for a history of sexual trauma. The focus groups were led by a clinical psychologist and a gynecologic surgeon. Interviews were audio-recorded and transcribed professionally, then coded in NVivo 12, and a content analysis was used to derive themes using the participants’ own words.

RESULTS: Women with chronic pelvic pain, regardless of history of sexual trauma, experience delay in diagnosis with repetitive dismissals by healthcare providers. Women’s experiences of dismissals included: (1) providers not listening to the patient; (2) making assumptions about sexual practices and fertility desires; (3) allocating insufficient time to appointments; and (4) performing redundant medical testing (i.e., STI testing, urine cultures). We unexpectedly found that the women without a history of sexual trauma living with chronic pelvic pain experienced similar degrees of trauma that stemmed from their interactions with the healthcare systems. Women in all focus groups described significant isolation, accentuated by the shame inherent to gynecologic conditions, insurance barriers to care, and lack of a healthcare advocate. Women valued a long intake appointment, consistency in providers, and being given the choice of when and how to disclose a history of trauma – sexual and/or otherwise. Behavior of office staff, tone of voice of team members answering the phone, and clinic environment are important to building or breaking trust, and creating a safe physical space to access care is paramount. Participating in a focus group with other women with similar experiences was helpful and promoted a sense of community while providing the safety of anonymity.

CONCLUSION: Women with chronic pelvic pain, with and without a history of sexual trauma, experience trauma due to interacting with the healthcare system. They have clear needs and preferences regarding the delivery of gynecologic care, and have feasible suggestions for improving the clinical environment. Focus groups promoted an environment of healing and community.