

Empathy During Patient-Provider Interactions for Women With Chronic Pelvic Pain: A Qualitative Study

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ABSTRACT

Background: Despite 25 years of evidence emphasizing problematic health care experiences for women with chronic pelvic pain and the benefits of clinical empathy and patient-centered care, negative patient-provider interactions for women with chronic pelvic pain persist.

Purpose: The purpose of the current study was to investigate the lived experiences of patient-provider interactions from the perspective of women with chronic pelvic pain.

Subjects: Thirteen women aged 18 to 65 years who had chronic pelvic pain for a minimum of 6 months and who had pursued medical consultation/care were included.

Materials/Methods: This phenomenological qualitative study used semi-structured, in-depth interviews. A topic guide was used for interview questions and consisted of 5 semi-structured questions with probes, as necessary. Each participant was interviewed face-to-face and one-on-one, and interviews were audio-recorded. Qualitative data analysis software was used to manually code and analyze the data through thematic nodes using an open and inductive approach and constant comparison to facilitate interpretive phenomenological analysis.

Results: Participants described negative patient-provider interactions during their health care encounters through patterns of health care provider behaviors and traits with a particular lack of empathy.

Conclusions: These findings highlight the need for improved integration of research into health care provider education to develop empathetic patient-provider interactions. Provider effort to help may be a major component missing in negative patient-provider interactions for this population. Cultivating positive patient-provider interac-

tions can advance best practices and ultimately result in the best care for women with chronic pelvic pain.

Key Words: health care provider behaviors and traits, patient experience, patient-centered care

INTRODUCTION

Chronic pelvic pain (CPP) affects up to 25% of women¹ and accounts for 10% to 33% of gynecological visits.^{2,3} However, diagnosis and treatment of women with CPP is poorly understood,^{1,3-6} and diagnosis for CPP conditions is often delayed by more than 10 years in the United States.^{6,7} The reasons for these delays are not well understood.⁶ Previous studies have investigated the biomedical and biopsychosocial models to better understand how approaches from different health care providers (HCPs) affect diagnosis and treatment for women with CPP.⁸⁻¹² Those studies concluded that HCP attitudes toward patients with CPP influenced the results of treatment, and insufficiency of qualitative and biopsychosocial aspects in health care contributed to lack of clinical resolution.⁸⁻¹² Such findings suggest patient-provider interactions (PPIs) are an important component influencing diagnosis and treatment for women with CPP.

Patient-provider interactions may be a factor in diagnosis delays for women with CPP. These interactions, aiming for interpersonal relationship, exchange of information, and inclusion of patients in decision-making,¹³ play a crucial role in quality health care and positive health outcomes.^{5,10,12-21} However, PPIs for women with chronic pain, particularly CPP, can be frustrating and strained, associated with negative perceptions, and emotionally burdensome to patients and providers.^{2,6-10,13,14,22-24} When caring for individuals with chronic pain conditions, empathy is an important component of successful PPIs and has been increasingly studied as a means of improving PPIs.^{2,10,11,13-17,19,25-28} Further, empathy is essential when practicing patient-centered care, which typically involves HCPs empowering patients to become active partners in their health care.¹⁰ Empathy is a

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“complex, multifaceted, and dynamic concept,”²⁹ but it is broadly described as the ability to connect with and share another person’s experience.^{28–30} The concepts of sympathy and compassion are often used interchangeably with empathy; however, sympathy and compassion are considered to arise from a self-oriented perspective of suffering experienced by someone else.²⁹ Empathy, in contrast, involves understanding, sharing, and acting within the experience of another person.²⁹ More specifically, clinical empathy requires the provider to understand a patient’s situation, perspective, and feelings; communicate that understanding and confirm its accuracy with the patient; and act on that understanding for the benefit of the patient.²⁵ Therefore, research is needed to better understand diagnosis delays in relation to PPIs, empathy in clinical practice, and the effects of these factors on the diagnosis and treatment of women with CPP. Results from such studies may be applied in practice to decrease delays in diagnosis and, consequently, improve treatment.

Although perspectives of PPIs from women with CPP have been previously investigated,^{7,8,23,24,31} many of these studies were conducted 25 years ago. More recent research investigating the benefits of patient-centered care and the influence of PPIs on patient experiences and health outcomes^{10,12,20,32} highlights the need for current studies of women with CPP. However, integration of research findings into clinical practice can be challenging.¹⁸ For example, it is difficult to perform randomized controlled trials about PPIs that are clinically meaningful because of diverse circumstances, characteristics, and illnesses of individual patients.^{17,25} In clinical practice, PPIs are more complex, dynamic, and variable than can be accounted for in randomized controlled trials.¹⁸ The additional dimension of multicausality of CPP and how such multicausality interacts with patient-provider relationships or influences their outcomes amplifies these limitations. This incongruity between research and clinical practice underscores the complexity of investigating PPIs for women with CPP.

Because of the many interrelated, interactive, and dynamic components of PPIs when treating women with CPP, a systems theory-based approach may be appropriate.^{33–35} Congruent with the systems model, using the biopsychosocial model includes consideration of the physical, psychological, emotional, and social influences and repercussions of CPP.^{9–11} When investigating multidimensional interactions, such as PPIs for women with CPP, quantitative research designs can be limited, so a qualitative, systems theory approach may be better suited to determine the health care experiences of this population.

The purpose of the current study was to investigate and describe the lived health care experiences of PPIs

for women with CPP. A primary goal of the study was to determine how potential themes and patterns of interpersonal health care experiences of women with CPP affected their medical care. Specifically, the researcher investigated how women with CPP described their health care experiences when pursuing diagnosis and treatment/management options for pelvic pain conditions and the level of empathy they received from HCPs regarding their difficulties for coping and living with CPP. Another goal was to identify areas for health care education to improve communication, build rapport, and convey empathy for better quality health care for women with CPP.

METHODS

Design

The current study used a phenomenological qualitative design. Semi-structured, in-depth, individual face-to-face interviews were used to describe the lived experiences of PPIs for women with CPP. The interviews took place on the campus of a large health sciences university in the Southwestern United States from September to October 2019. This qualitative approach was used in the current study because phenomenology, focusing on commonality of a lived experience from the first-person point of view,³⁶ was designed for experiential research and is ideal for assessing an individual’s lived experiences, such as illness and medical experiences.^{36,37}

To minimize potential researcher bias, credibility, dependability, confirmability, and transferability were maintained during the study, as explained in the following statements. A topic guide was created to provide structure to interviews, but participants were encouraged to speak freely about issues they deemed important (Appendix). The topic guide was refined through a pilot interview and instrument audit by 2 experienced qualitative researchers to support its validity and reliability. To reduce bias and maintain the validity and reliability of collected data, the author conducted all interviews for consistency, avoided asking leading questions, took notes during the audio-recorded interviews, allowed participants to clarify their points, and facilitated member checking for participants to confirm the accuracy of their interview data.³⁸ The author was transparent and reflexive (critically aware and self-reflective about preconceptions, relationship dynamics, and analytic approach³⁹) about the processes by which data were collected, analyzed, and presented. For example, the researcher continuously considered her position and preconceptions as a pelvic physical therapist while developing the research questions and topic guide, interviewing participants, and analyzing data. Acknowledging these potential sources of researcher bias facilitated critical review. In

addition to third-party review, this evaluation of how questions were formulated, posed to participants, and interpreted was intended to more directly mitigate potential bias from the researcher during data collection and analysis. Although the author had limited experience with qualitative research, she had support and guidance from 2 experienced qualitative researchers throughout this project.

Participants

Voluntary participants were recruited through women's health and pelvic health physical therapy Facebook pages and by referral from local pelvic physical therapists. Nonprobability, purposive sampling was used to select participants based on study goals.⁴⁰ Inclusion criteria were adult females aged 18 to 65 years who had CPP for a minimum of 6 months, per the definition of CPP,^{1,3,4} and had sought medical consultation or care. Potential participants were excluded if their pain did not meet the definition of CPP; their pelvic pain was specific to menstruation, intercourse, pregnancy, or malignancy; they did not speak English; or they were unable to cooperate with study procedures. Participants also had to be willing to travel to the campus of the health sciences university to participate in face-to-face interviews. Recruitment, data collection, and data analysis occurred simultaneously until theoretical/data saturation was achieved (more information about saturation is provided below), which was determined by the author when no new themes emerged after analysis of 3 consecutive transcripts.

The current study was considered exempt by the local institutional review board. Written informed consent was collected from participants before beginning the interview and detailed the study purpose, use of the audio recording for data collection, ability to withdraw from the study without penalty, and information about confidentiality for the participants and their information. No compensation or incentive was offered to participants, and travel costs were minimized by recruiting participants within a 90-minute driving distance of the interview location.

Data Collection

To maintain participant confidentiality and data credibility during data collections, participants were assigned a random identification number for use on all data collection materials and files. The file linking participant names with identification codes was kept separate from all data materials and stored on a password-protected computer that only the author could access. The author reviewed the study purpose with each participant and explained the goal of understanding the participant's perspective of her health care experience(s) with CPP. After written informed consent

was obtained, the interview was started using the topic guide, and the researcher began the audio recording and note-taking. The duration of each session was approximately 1 hour. Credibility and trustworthiness were addressed by gathering rich data to explore the complexities of the research topics and using thick descriptions through observation and interpretation of contextual detail and meaning of collected data.⁴¹ Member checking, whereby each participant reviewed and evaluated accuracy of data collected from her interview,⁴¹ was also used since only the participants could adequately judge whether the data were credible.

Data Analysis

Data gathered from the interviews were transcribed from the audio recordings by a professional research transcription service. Transcriptions were then compared with the audio recordings by the author for accuracy and were de-identified by replacing specific names with generic place holders. Before uploading the text document into NVivo qualitative analysis software,⁴² the author e-mailed the transcript of each interview to the appropriate participant for member checking. This process enabled participants to ensure credibility of collected data by confirming their experiences were accurately represented.

Once the files were imported into NVivo, coding began using interpretative phenomenological analysis through an open, inductive approach with constant comparison. This data analysis method was chosen because it has been widely used in qualitative research investigating illness experience.⁴³ Data coded to thematic nodes were reviewed for similarities and differences in the participants' experiences, particularly in reference to PPIs and HCP empathy. Prominent nodes that emerged from analysis of the transcripts included the effect on life/activities affected, emotional toll, medical error, information/resources, advocate, plan, diagnosis, listening, dismissed/ignored, believing, taking seriously, normalizing CPP, trust, blamed/shamed/judged, psychosomatic, conditioned into silence, HCP knowledge, HCP effort, HCP honesty, and HCP compassion. Visual maps, such as word clouds, word trees, and connection diagrams, were used to explore and assess relationships among codes to determine connections with key concepts. All interviews were analyzed, but theoretical/data saturation was reached after analysis of data from participant 11. Saturation generally means that no more patterns are emerging and no new themes are being generated from the data.⁴⁴ For the current study, saturation was defined as no new themes emerging during analysis of 3 consecutive transcripts.

When assessing the integrity of the results, credibility, transferability, dependability, and confirmability were considered.⁴⁵ Credibility was substantiated

through constant data comparisons, where each interpretation and finding was compared with previous findings as new findings and interpretations emerged through data and refutational analyses.⁴⁶ Transferability was established by using rich descriptions of the findings, and the population was purposively chosen to collect data from individuals with experiences relevant to CPP. Dependability was ensured by considering alternative explanations and interpretations of the findings, and the results and conclusions were reviewed with 2 additional experienced qualitative researchers through peer debriefings. Debriefings allowed research peers to review transcripts, emerging codes, and thematic findings in search of overemphasized or underemphasized points, alternative coding, and rival hypotheses.⁴⁷ Confirmability was established through an audit trail of data collection, data analysis, and interpretation rationale,⁴⁸ which was also reviewed with peers.

RESULTS

Data from 13 participants were analyzed, and participant characteristics are presented in Table 1. Participants described their health care experiences when seeking diagnosis and care, indicating a pattern of behaviors and traits exhibited by HCPs in response to their CPP. Their descriptions, both negative and positive, highlighted emergent themes and illustrated their experiences with CPP during encounters with HCPs. Through their descriptions, certain HCP behaviors and traits were emphasized that directly described empathy or interactions with provider empathy in relation to PPIs. The salient themes, HCP behaviors and HCP traits, and related subthemes are presented in Figure 1. The interconnections among

Table 1. Demographic Characteristics of Study Participants (N = 13)

Demographic Variable	n (%) or Mean (SD)
Race and ethnicity	
White	9 (69)
Hispanic/Latino	4 (31)
Age ^a , y	38 (12),23-63
Years living with CPP	16 (11)
Years between CPP onset and diagnosis ^b	12 (8)
Abbreviation: CPP, chronic pelvic pain. ^a Age is reported as mean (SD) and range. ^b Two participants were still seeking a diagnosis; therefore, the mean time between onset and diagnosis was based on data from 11 participants.	

subthemes in relation to the themes of HCP behaviors and HCP traits affecting PPIs for women with CPP are presented in Figure 2. The subtheme of being conditioned into silence was not referenced enough to establish substantial connections with any other subthemes.

Health Care Provider Behaviors and Negative PPIs

The theme of HCP behaviors contributing to negative PPIs for women with CPP included subthemes of participants feeling faulted by HCPs and dismissed by HCPs (Figure 1). In the current study, the term *behaviors* describes the way an HCP acted toward a patient. Examples of participants' statements regarding negative HCP behaviors are presented in Table 2. Participants described feeling faulted by HCPs through being blamed, shamed, and judged for CPP and being told or made to feel that the pain was "all in your head." As a result, participants felt conditioned into silence and apprehensive about seeking

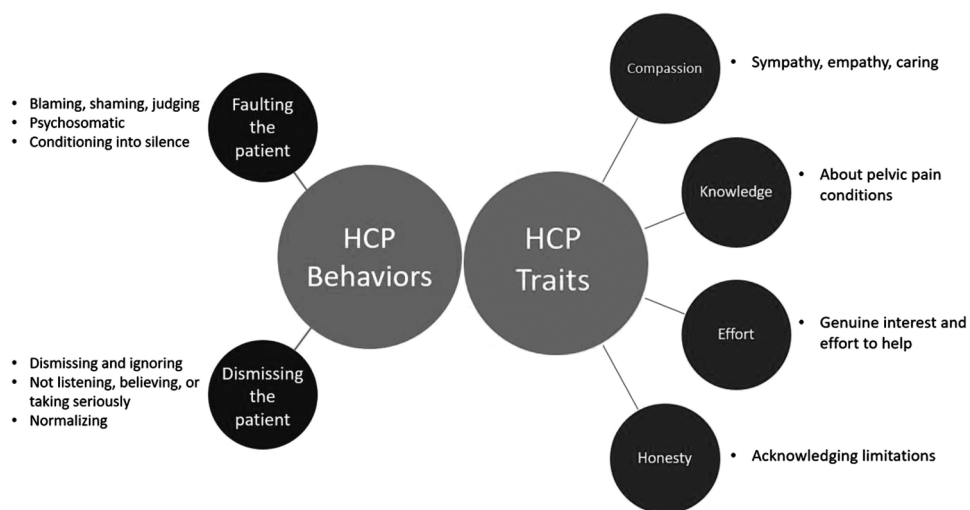


Figure 1. Health care provider (HCP) behaviors and traits influencing patient-provider interactions for women with chronic pelvic pain by subtheme.

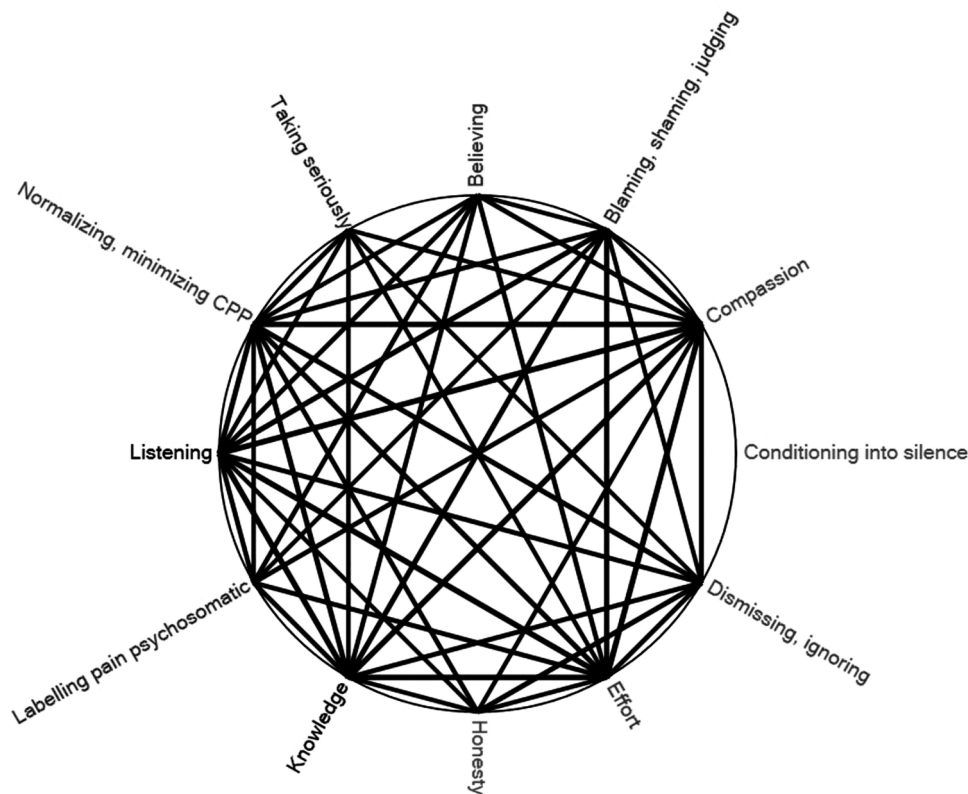


Figure 2. Subthemes of health care provider behaviors and traits influencing patient-provider interactions for women with chronic pelvic pain (CPP) clustered by coding similarity. The subtheme of being conditioned into silence was not referenced enough to establish substantial connections with any other subthemes.

further care because of these negative experiences. Participants often felt HCPs dismissed them or did not listen to their accounts of CPP. Even when they felt HCPs listened to them, participants often felt their HCPs did not believe them or take them seriously. A common experience was normalization of CPP. Participants were often made to feel their CPP was a “normal woman problem.” One participant described the negative aspects of these PPIs in the following way: “As far as them saying, ‘It’s all in your head,’ ‘It’s not really happening,’ or ‘You’re making it bigger than it is’—these are all things that I actually heard from physicians in saying that I’m actually doing this to myself.” After feeling blamed by an HCP for her experience with CPP, another participant stated, “Back to my fault, back to me. Back to blaming myself on top of the doctor blaming me. That’s a heavy load to carry.”

Having CPP labeled as psychosomatic had far-reaching psychosocial effects on the lived experiences of participants (Table 2). As one participant explained, “I started to believe them. After so many times of being told that it was all in my head, I started to doubt myself—doubt my own intuitions.” Another participant stated, “[The provider] knows more about medicine than I do. My doctors have told me

everything is fine. I must just be crazy.” After experiencing PPIs with these HCP behaviors, participants became more reluctant to report their symptoms and seek care for their CPP. As one participant explained, “I had been trained to stop talking about my pain; otherwise, I would be referred to a psychologist.”

Beyond normalization of CPP to menstrual or womanly issues, one participant referenced the subtheme of CPP being normalized in relation to other subthemes when she stated, “One hundred percent, I was treated like it was, one—a women’s issue and therefore not important, and two—must be something that I had caused. I fully believe that the fact that I am a woman meant that a lot of my pain was dismissed. That makes me so angry!”

Health Care Provider Behaviors and Positive PPIs

Participants also described positive PPI experiences with more productive communication (Table 3). A common experience, or journey, described by participants was going through a series of negative PPIs (across multiple HCPs and multiple years) before finally finding an HCP for CPP with whom they experienced positive PPIs. The PPIs with these HCPs were different because the provider listened to them, believed them, and took their reports and

Table 2. Descriptions From Study Participants of Health Care Provider Behaviors and Traits Negatively Influencing Patient-Provider Interactions by Subtheme

Subtheme/Subtheme Component	Participant Statements
HCP behaviors	
Blaming, shaming, and judging	It turned back on me. That I either did something to deserve it, or that I was making it up.
	I approached those encounters with a lot more anxiety and almost with shame.
	I almost feel like I'm being judged when I'm there for my pelvic [pain], like I brought it on or something.
Labeling pain psychosomatic	Have people directly said, "It's all in your head?" Oh, absolutely. I had several doctors say that to me.
Conditioning into silence	Basically, you know that there's a problem, and it's really upsetting you, but every time you try and bring it up, you're told, "Oh, that's not important," "Oh, you're imagining things," "Oh, it's not real." Most of what I experienced was just being pressured into silence. What I ended up doing is just not talking about it to anybody and just bottling it up.
Dismissing	I was "written-off." I didn't fit into their box of what they see and treat all the time, so they didn't want to deal with me.
Not listening, believing, or taking CPP seriously	They kind of assume what's going on, instead of actually listening to the patient.
	I don't think she believed I actually had the pain I was in.
	They don't take me seriously when I'm there for pelvic [issues].
Minimizing CPP as "woman problems"	"All women have this. Why are you making such a big deal out of it?"
HCP traits	
Knowledge and honesty	I wish that they would've just said that to me rather than BS-ing their way through other diagnoses or down-playing my symptoms. I think a lot of it was that they just didn't know. They didn't know, but they didn't want to say that they didn't know.
Knowledge of CPP and effort	It's okay that you don't know, but please help me. Either can you find the information to help me? Can you refer me to someone that you think will actually help me instead of brushing it off as a passing thing?
Honesty and effort	I'd rather have the one that's honest and interested and wants to research and help.
Abbreviations: CPP, chronic pelvic pain; HCP, health care provider.	

concerns about CPP seriously. From a participant's perspective, being taken seriously meant that her concerns were regarded as important and worthy of attention. Being believed by HCPs interacted with other subthemes and was particularly meaningful to

participants. One participant explained, "I burst out crying because I finally was like, 'Finally, somebody believes me. I'm not being crazy.'" This statement underscores the relationship between participants feeling their HCPs did not believe them or feeling

Table 3. Descriptions From Study Participants of Health Care Provider Behaviors and Traits Positively Influencing Patient-Provider Interactions by Subtheme

Subtheme/Subtheme Component	Participant Statements
HCP behaviors	
Listening	I cried again, of course, because I was finally being heard. I finally felt like I could get somewhere.
Believing	The first doctor in the ... 13 years, probably, of going to doctors for my problems, to actually have one that believed me. It was weird. It was different. It didn't feel normal.
Taking CPP seriously	That was the first time in more than a decade I'd been taken seriously about my pelvic issues.
HCP traits	
Compassion	They were compassionate, and they were going to help work towards finding answers with me.
Knowledge	That was amazing. I was actually in a little bit of shock there to even find a physician that was so caring at that point, and more knowledgeable, it seemed, than the five other "specialists" in the field.
Effort	I remember her telling me numerous times, "We're going to get you answers." I really felt like she was going to do all that she could to get those.
Honesty	I switched to another gynecologist who was absolutely honest, just to my face from the get-go: "Listen, I can't find this pain. I know it exists and I hear you, but I don't know what to do."
Abbreviations: CPP, chronic pelvic pain; HCP, health care provider.	

crazy and the subtheme of being told the pain was psychosomatic or “all in your head.”

Health Care Provider Traits and Negative PPIs

The theme of HCP traits contributing to negative PPIs for women with CPP included subthemes of HCPs lacking compassion, knowledge, effort, and honesty (Figure 1). In the current study, the term *traits* describes qualities or characteristics belonging to or demonstrated by an HCP. Examples of participants’ descriptions of negative HCP traits are presented in Table 2. When describing PPIs during which the HCPs often lacked compassion, one participant stated that the HCP had “Zero empathy. She seemed cold and disbelieving She felt very detached as well.” Another participant stated, “I feel like they don’t empathize or even try to.”

The importance of HCP knowledge about pelvic pain conditions was a major subtheme, and several participants emphasized finding a provider who would finally know how to help them identify and address their CPP. As one participant stated, “There was this huge gap in knowledge ... there was a lot of lack of information I remember one particular provider said she didn’t even believe that [pelvic pain diagnosis] really was a real, true diagnosis.” However, the subtheme of HCP knowledge, alone, did not fully illustrate the participants’ perspective. Although participants were searching for HCPs knowledgeable about pelvic pain conditions, they viewed PPIs more negatively when they felt HCPs discounted their CPP instead of being honest in admitting limitations in knowledge or experience with CPP (Table 2).

In addition to HCP knowledge of CPP, participants highlighted the efforts of HCPs willing to help with their condition as being just as, if not more, meaningful (Table 2). Lack of effort and willingness to help from HCPs contributed to negative PPIs, as expressed in the following statements: “I don’t necessarily know that they were willing to get to the bottom of the diagnosis or really figure it out,” “I think in some cases they didn’t care if I came back because they really didn’t have the answers, and maybe they didn’t want to put forth the effort to find those,” and “It was like she didn’t even want to research or even go a step further.”

An interaction became evident between the subthemes of HCP knowledge and effort to help; specifically, participants were less concerned about an HCP’s lack of knowledge if the provider demonstrated an effort to help (Table 2). This interaction was summarized in the following participant statement: “I’m totally fine if a doctor says to me, ‘I don’t know.’ If they tell me, ‘I don’t know, but we’re going to find out, and I will do the research needed. I will make the

proper phone calls, or my staff can help with those things.’ I am totally fine with that because I know that not every person knows everything.” This interaction between the subthemes of knowledge and effort was described in such a way that it could redirect a negative PPI related to lack of HCP knowledge into a positive PPI based on HCP effort to help.

Health Care Provider Traits and Positive PPIs

As illustrated through the subthemes related to HCP traits, negative PPIs resulted when HCPs lacked compassion, knowledge, honesty, and effort during patient encounters (Figure 1). However, more productive and positive PPIs resulted when HCPs demonstrated compassion, knowledge about CPP, honesty, and effort to help (Table 3). Again, a common experience described by participants was having gone through many negative PPIs with various HCPs before encountering an HCP with whom they had positive PPIs. One participant explained, “The fact that he was willing to figure it out, what it was, and treat my pain, that was the first that that had ever been said to me.” The following participant’s statement describing a positive PPI demonstrates the interaction between HCP traits of compassion, effort to help, and knowledge: “He was always compassionate and wanted to try and help me the best that he knew how to.” Furthermore, while participants considered it important to find a provider knowledgeable about CPP, participants also appreciated honesty from HCPs who recognized the limits of their knowledge and experience. One participant explained it in the following way: “If they’re going to be kind enough and respectful enough to say, ‘I don’t know, but we’ll get you some answers, or we’ll get you a referral to a person who can get you those answers’—I think that’s the next step.”

DISCUSSION

The current study investigated the lived health care experiences of PPIs for women with CPP. From participants’ descriptions of their PPI experiences and level of empathy demonstrated by their HCPs, many interconnected themes were identified with a common thread of empathy and related constructs. Participants also emphasized several HCP behaviors and traits toward women with CPP that shaped PPIs. For example, positive PPIs involved HCPs listening to, believing in, and taking patients seriously while demonstrating compassion, knowledge, effort, and honesty. These descriptions support the components of clinical empathy²⁵ and HCP understanding and communication of patient situations, perspectives, and feelings. The subtheme of HCP effort to help more specifically represents the third aspect of clinical

empathy, which describes the ability to act with empathetic understanding to benefit the patient.²⁵ With regard to descriptions of empathy, sympathy, and compassion provided earlier, participants often used these terms interchangeably to express similar meaning. The participants' words guided the terms used during coding for data analysis; hence, the sub-theme of compassion fell under the theme of HCP traits. However, all participants in the current study highlighted the trait of empathy from HCPs, which reinforced other provider behaviors. Thus, when an HCP expressed compassion for a participant's concerns, the participant had a sense of being listened to, believed in, and taken seriously. Ultimately, these behaviors can foster a feeling of validation for participants' experiences of CPP, which supports existing evidence of women with CPP seeking validation from HCPs.²³

However, participants described HCP behaviors and traits in response to CPP that negatively, even detrimentally, affected PPIs. A common lived experience that emerged across participants consisted of a series, usually of several years' duration, of negative PPIs with multiple HCPs before finally finding an HCP who was different and with whom they experienced positive PPIs. Therefore, the data included many more descriptions of negative PPIs than positive PPIs. Negative PPIs involved HCPs faulting participants for CPP, labeling CPP as psychosomatic, dismissing participants, and normalizing the difficulties of women with CPP. They also involved HCPs not listening to, believing in, or taking the participants seriously. Some of these behaviors, including listening to and taking patients seriously, have been discussed in previous studies related to women with CPP.^{6-9,22-24,31,49} These behaviors and traits from HCPs may cause patients to feel invalidated³⁰ because they are dismissed, ignored, or directly contradicted by HCPs. Moreover, the descriptions of HCP behaviors and traits in the current study were contrary to clinical empathy and highlighted aspects of PPIs that should be addressed to advance practice and improve health care for women with CPP.

Participants in the current study also emphasized the connection between an HCP's knowledge and effort to help, which revealed a remarkable interaction. The HCP trait of knowledge was frequently discussed in conjunction with, but secondary to, HCP effort to help the patient. This connection between objective and subjective provider characteristics¹³ emphasized the importance of HCPs paying attention to patients' symptoms, concerns, and expectations to achieve positive PPIs and outcomes. Participants were less concerned about an HCP's lack of knowledge if the provider exhibited a genuine effort to help. Discussion of patient perception of provider effort

appears to be lacking in the literature, so this finding of the current study may be unique. Because provider effort represents the third component of clinical empathy (ie, acting on empathetic understanding in a way that benefits the patient),²⁵ HCP effort may be a major aspect of empathetic and patient-centered care needed to achieve beneficial PPIs and clinical resolution. Perhaps the action component (the HCP's effort to help) is the missing link between previous studies for empathetic patient-centered care and actual PPIs in practice.

The current study had several limitations. While some aspects of data collection were beyond the author's control, measures were taken to minimize researcher bias. For instance, the study population was limited to women who were able to travel to a specified location in a metropolitan area in the Southwestern United States to participate in face-to-face interviews. Although the sample size of 13 was considered adequate for a phenomenological study and saturation was reached after 11 interviews, the exact point of saturation is debatable.^{50,51} Further, only 2 race and ethnicity categories were represented in the study (White and Hispanic/Latino), but those categories represent the general population of the local geographic area. However, the results may not be generalizable to other geographic areas. Although other participant conditions were discussed during interviews, such as having private health insurance or Medicaid or paying out-of-pocket for health care services (all of which were represented in the study), this data was not formally collected or analyzed. Similarly, some participants described health care experiences that spanned multiple states, and all participants conveyed health care experiences across multiple clinics, health care disciplines, and providers. But again, such data were not formally collected or analyzed. Another limitation is that voluntary response bias may have occurred because only volunteers who met the delimitation criteria participated in the study. Therefore, some participants may have volunteered because they had a particular interest in sharing overly positive or negative experiences.

Because self-reported data can be "limited by the fact that it rarely can be independently verified,"⁵² it may be prone to potential biases, such as selective memory, telescoping, attribution, and exaggeration. Although these biases are worthy of consideration, the purpose of the current phenomenological study was to explore and describe the lived experiences of women with CPP with respect to PPIs. Therefore, their perspectives, along with their potential biases, were relevant to their lived experiences, components of their experiences (ie, perception, thought, memory, emotion, and social interactions), and the meanings attributed to those experiences.³⁶

A persistent concern with qualitative research is that the researcher's own values and opinions may be reflected in the study questions, data collection methods, and findings.³⁹ Because researchers are an integral part of the qualitative research process, "separation from this is neither possible nor desirable."³⁹ However, the author aimed to be transparent and reflexive about how data were collected, analyzed, and presented. Researcher bias may have occurred because of the author's clinical work as a pelvic physical therapist treating women with CPP and, thus, affected the way questions were formulated and the analysis conducted. To minimize this bias, credibility, dependability, confirmability, and transferability were maintained throughout the study as much as possible. Although researcher bias cannot be absolutely controlled, it was partially offset by the author's familiarity with the topic area, and the additional expertise may have contributed to more in-depth understanding of the participants' responses. Moreover, the data and findings of the current study were reviewed by 2 additional experienced qualitative researchers through peer debriefings, further offsetting researcher bias.

The results of the current study may be useful to inform HCPs and HCP educators about aspects that contribute to positive and negative PPIs for women with CPP. In particular, positive PPIs resulted when HCPs listened to, believed, and took patients' concerns seriously while interacting with compassion, knowledge, honesty, and effort to help. Therefore, cultivating those HCP behaviors and traits into PPIs will benefit health care experiences for women with CPP. However, to increase the generalizability of findings, additional research is recommended that includes a more diverse representation of racial and ethnic populations and locations/regions. Future studies could also investigate how various aspects of PPIs influence diagnosis and health care for women with CPP. Based on salient themes from the current study, additional studies could explore effective educational techniques for inculcating empathetic communication and interactions with patients as part of HCP training skills. Although a qualitative research design was most appropriate for the current study, the resulting themes may be useful for developing quantitative assessment tools to investigate these experiences and outcomes across larger sample sizes and to triangulate with and further support findings of qualitative data. Through research and improved health care education for HCPs, educators and providers can take steps to advance best practices and maximize diagnosis, treatment, and health care outcomes through empathetic PPIs. Ultimately, the goal of such studies should be to alleviate the physical and emotional suffering of women with CPP by providing better quality care.

CONCLUSIONS

Overall, the findings of the current study illustrated aspects of PPIs that support the need for an empathetic approach to health care for women with CPP rather than ones that inhibit an empathetic approach. Findings also highlighted the profound effect PPIs had on women with CPP and their health care experiences. Even though there is much research on patient-centered care, clinical empathy, and the influence of PPIs on patients' health care experiences and health outcomes, the findings of the current study indicated that detrimental patterns in PPIs are common and persistent for women with CPP. These findings also confirm and emphasize a lack of empathy from HCPs for women with CPP, which results in negative PPIs. For example, participants were dismissed, ignored, blamed, or not believed by HCPs, which encumbered the health care process. Overall, study findings support existing research that highlights the necessary progress to improve health care experiences and advance health care outcomes for women with CPP by cultivating empathy in PPIs.

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APPENDIX. Interview Questions Topic Guide

Key questions asked during the interviews to answer the research questions included the following:

Interview questions #1 and #2 were relevant for background information and for context of each participant's CPP condition(s) and individual factors related to their lived experience of CPP condition(s).

- 1) Less sensitive, background/demographic questions to track age, race and ethnicity, pelvic pain condition/diagnosis (if any or multiple), number of months/years with CPP, and other medical and/or psychological diagnoses.
 - a. American Indian or Alaska Native
 - b. Asian
 - c. Black or African American
 - d. Native Hawaiian or other Pacific Islander
 - e. Hispanic or Latino
 - f. White
- 2) "I understand that you have experienced chronic pelvic pain. Tell me more about your history of pelvic pain."
 - a. Probe: age of onset
 - b. Probe: effect of pelvic pain on ability to participate in activities of daily living
 - c. Probe: effect of pelvic pain on relationships

Research question #1: How do participants with CPP describe their health care experiences when seeking diagnosis and treatment/management options for pelvic pain conditions?

Research question #2: How do participants with CPP describe the level of empathy from providers involved in their health care experiences regarding the difficulties of coping and living with CPP?

- 3) "Tell me about some of your experiences interacting with healthcare providers related to your CPP."
 - a. Probe: "Describe your relationship with the provider/providers."
 - b. Probe: "How do you feel your healthcare provider treated you or acted towards you?"
 - i. For the researcher—in the context of empathy: an ability to connect with another person's experience³⁰; traits supported by the following²⁸: (1) empathetic

concern, (2) perspective taking, and (3) empathetic matching—alignment of the listener's/observer's emotions in response to the individual having or communicating the experience.⁵³

- c. Probe: "How does this encounter related to CPP compare with encounters you have had for other health conditions?"
 - d. Probe: "How would you describe the level of trust between you and your provider?"
 - e. Probe: "Did you feel/how did you know that your provider understood your concerns?"
 - f. Probe: "How did you feel during and/or after that/those encounters with the health-care provider?"
 - g. AT THE END (if dialogue related to empathy from providers has not been discussed): "What was your experience regarding the healthcare provider's level of empathy toward your difficulties with CPP?"
- Research question #3: How does the patient-provider relationship affect the diagnosis and care of women with CPP?
- 4) "How did you feel about your ability to take steps toward management of your pelvic pain after the encounter with the healthcare provider(s)?"
 - a. Probe: "What did you learn about your CPP condition from your provider that was either new or helpful information in managing your condition?"
 - b. Probe: "What type of information or resources were provided to you to help you better understand your CPP condition? Were the information/resources helpful? Why/why not?"
 - c. Probe: "Has your CPP changed over the course of treatment: better/worse/no change, frequency, intensity, quality/description?"
 - d. Probe: "Were there other aspects of the encounter that were helpful? Not helpful? Please describe those."
 - 5) "Describe what you expected or hoped to experience at the encounter with the healthcare provider regarding your CPP?"
 - a. Probe: "Were your expectations met or disappointed based on the encounter(s) with healthcare providers related to care for your CPP? Please describe how your expectations were met/disappointed."