

The Legitimization of Pain in IUD Insertions

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A Note on the Use of “Legitimization”

Throughout my thesis, I use the term “legitimization” to describe how pain has historically been and is currently thought about in relation to IUD insertions. While not a clinical term, “legitimization” goes beyond simply recognizing, understanding, validating, or addressing pain—it brings all of these actions together into one comprehensive concept. Legitimizing IUD insertion pain means that practitioners not only acknowledge the pain but also take meaningful steps to address it. The term also implies a broader, more formal recognition by the medical establishment, signaling that this pain is not just real, but worthy of attention, research, and action.

Introduction

Intrauterine devices (IUDs) are a highly effective, long-lasting, and convenient form of birth control. Yet, the public and media discourse widely describe the IUD insertion procedure as incredibly painful and uncomfortable, often citing negative patient experiences shared on social media platforms like TikTok. However, the existing medical and scientific literature on IUD insertions does not have a clear consensus on the pain, with characterizations of the procedure ranging from not painful to mildly painful (Hubacher et al.), somewhat uncomfortable (Akintomide et al.), to moderately or severely painful (Hall and Kutler). The discrepancy between patient concerns and medical researchers and practitioner's understanding of IUD insertion pain highlights broader issues within the medical field: practitioners' tendency to minimize women's pain, patient mistrust in obstetrics and gynecology, and the gaps in women's health research. Through considering the potentially painful aspects of the procedure, discussing the options for pain relief, understanding the tumultuous history of gynecology, and unpacking the patient and practitioner perspectives on insertion pain, I plan to introduce the ways that IUD insertion pain has been legitimized and the ways it still needs to be legitimized and addressed.

When there are no complications, the IUD insertion procedure takes between 3-4 minutes (Gupta, "Getting an IUD"). First, the practitioner will insert a speculum—an instrument resembling a duck's bill that is used to gently open the vaginal walls—into the vagina to allow a better view of and access to the cervix. Then, a tenaculum—an instrument that looks like a pair of scissors with sharp, pointy ends—is used to grab onto the cervix to stabilize it and to straighten out the uterus. As the tenaculum ends are extremely sharp, the grabbing can poke small holes in the cervix and cause minor bleeding, both of which can be associated with pain (Gupta, "Will This Antiquated"). Then, a uterine sound—a long, thin rod made of metal or

plastic—is inserted into the cervix to measure the uterus's length, direction, and patency (its openness or lack of obstruction) (“Uterine Sound - Knowledge and References”). The manipulation of the uterine sound can be associated with a lot of pain, discomfort and cramping, as the cervix is physiologically closed and therefore can require a lot of force to push through. This pain is generally more intense for nulliparous women (women who have never given birth) because their cervix is typically less open (Gupta, “Getting an IUD”). Following the uterine sounding, the IUD is placed on the inserter tube and this IUD+tube apparatus is slowly inserted into the uterus to ensure correct positioning. This insertion can cause pain similar to the uterine sounding, as the cervix is again being manipulated. The tube is then pulled back a little to deploy the arms of the IUD to the proper “T” position. Finally, the insertion tube, tenaculum, and speculum are removed (Johnson). When the IUD is inserted into the uterine cavity, it causes contractions and cramping as the cervix adjusts to accommodate it (“IUD Pain”). This can cause pain and discomfort during the insertion and even for several days after. According to one study with parous women (women who have given birth to one or more children), the strongest pain associated with the procedure was the uterine sounding and the IUD insertion (Maguire et al.). It is also important to note that since women have anatomical differences beyond those related to parity, these experiences of pain are not equivalent or universal. Previous history of obstetric, gynecologic, and/or sexual trauma can also exacerbate pain and discomfort during the procedure.

Although several steps of the IUD insertion procedure can cause pain, there is no standardized approach for providing pharmacological pain relief. The most commonly recommended pain relief option is taking non-steroidal anti-inflammatory drugs (NSAIDs), e.g. ibuprofen before the procedure (Daidone et al.), though many studies indicate that they are not very effective for reducing IUD insertion pain, though they can help with post-insertion cramps

(Rahman et al.). However, some studies indicate that the NSAIDs, ketorolac (Crawford et al.), naproxen, and tramadol (Karabayirli et al.) administered orally have been shown to be effective in reducing pain during the procedure. Less widely used for IUD insertions but shown to be relatively more effective are 1% lidocaine paracervical blocks. A paracervical block is a local anesthetic administered by an injection into the tissue surrounding the cervix, and has been shown to reduce pain during the procedure by some studies (Mody et al.). However, it is important to note that the actual administration of the paracervical block can be painful. Thus, there are concerns about whether this pain is better or worse than the IUD insertion pain. Other forms of local anesthesia applied topically such as 10% lidocaine spray and 5% lidocaine-prilocaine cream were also found to be effective for pain relief and not painful when administered, though a study limitation is that all the participants were parous. While some studies supported the efficacy of misoprostol—a drug that makes the cervix softer and easier to go through, and is more commonly used to induce abortions—in relieving pain during the procedure, others found that it was not only ineffective for pain relief, but also responsible for additional adverse side effects (*FSRH Statement*). Furthermore, the latest CDC guidelines do not support the use of misoprostol unless initial attempts to insert the IUD do not work (Curtis). Other recommendations on non-pharmacological methods of pain management include addressing patient anxiety about the procedure, as anxiety is associated with higher ratings of pain (Rahman et al.). There have also been efforts to design new tools such as a less-painful alternative to the tenaculum (Gupta, “Will This Antiquated”), though more research needs to be done to test its efficacy.

The research is overall inconclusive on what the best methods of pain relief are for IUD insertions, especially for nulliparous women. This lack of clarity in pain management stems from

gaps in research. Many of the research studies on IUD insertion pain management are either only limited to parous women or they do not adequately stratify the data for parous and nulliparous participants. This can contribute to misleading results as parous women overall report lower levels of pain during the procedure, and there is also evidence that lactating women experience less insertion pain compared to non-lactating women. While the research is comparatively limited on nulliparous women, pain management is still under-researched for both populations. Further limitations of existing studies include small sample sizes, not considering the type and/or size of different IUDs, and not accounting for past sexual and gynecologic history of participants (Rahman et al.). Moreover, the fact that some studies testing the same pain management methods have different results poses another obstacle in identifying the most effective interventions. The impact of anticipated pain, demographics such as race, and psychological factors such as anxiety on the experience of IUD insertion pain also need to be further researched (Rahman et al.). Other patient populations that are also heavily under-researched are transgender and gender non-conforming individuals who have a uterus and seek to prevent pregnancy (Guss). Thus, not only is more research needed, but specifically more comprehensive, standardized, and stratified data needs to be collected.

These gaps in research can be attributed to misperceptions regarding IUD use for nulliparous women and the relative recency of IUD users speaking out about the pain they experienced during IUD insertions. Ten to fifteen years ago, the target patient population for IUDs were parous women who wanted long-lasting and convenient birth control after having kids. The prescription information for certain IUDs prior to and during this time recommended its use for parous women, and misconceptions about the dangers of IUDs (such as fears of infertility) for nulliparous women contributed to its limited use among this population (Lohr et

al.). Accordingly, the rate of IUD use was 3 times higher among parous women compared to nulliparous women during that time period (Branum and Jones). Moreover, the paucity of nulliparous participants in previous studies may also be due to this limited patient population. In recent years, however, this gap has been narrowing, with more nulliparous women being offered IUDs and choosing to get them. This increase may be linked to the more recent and widespread accounts of painful IUD insertions, as nulliparous women have reported higher levels of pain during the procedure. Some parous women have also reported feeling intense pain during their IUD insertions (O'Donohue), thus the overall increase in the sharing of painful IUD insertion experiences has contributed to more patients, physicians and researchers calling for more comprehensive pain management research.

While the increased calls for research are necessary and important, medical practitioners' reliance on evidence-based practice means that many women's pain has not been and likely will not be adequately addressed until there is more conclusive data on the most effective pain management methods. Though evidence-based practice ensures accurate and research-backed medicine, problems arise when the data does not match the patient's experience. For example, some practitioners are taught that the IUD insertion procedure will feel like "a little pinch" and thus use similar language in describing the procedure to the patient. Such language can mislead the patient on what to expect and can lead to a traumatic insertion experience. When patients experience or express pain that is not in-line with the practitioner's understanding of the procedure's pain, there is no universal, comprehensive training or enforced guidelines for what practitioners should do. In this position of authority over the patient, practitioners have a decision to make: there can be an approach of person-centered care and shared decision-making to identify the best next steps with the patient, or there can be an abuse of power over the patient

and their experience, where the practitioner does what they feel would be best for the patient. Another complication of this phenomenon is that practitioners have been found to significantly underestimate the patient's experience of pain during IUD insertions (Akintomide et al.). Thus, the practitioner's perception of the insertion pain is likely inaccurate, which can lead to them inaccurately characterizing the procedure's pain to future patients. Though the latest CDC guidelines recommend that practitioners discuss the options for IUD pain management with their patients (Curtis), they are not enforced and are simply meant to be a clinical resource for practitioners. Regardless, this is a step in the right direction and indicates the shift in incorporating more person-centered care and shared decision-making in gynecology and medicine in general.

While gynecology has come a long way, it is important to recognize its tumultuous history and the historical basis for deeper, systemic issues of racism and the medical gaslighting of women's pain and health concerns. Practitioner's positions of authority over patients and the historical hierarchy of decision-making still impacts and exists in current medical practice. The introduction of obstetric anesthesia in the 1840s highlights this legacy, as medical opposition to its use primarily focused on whether it would benefit the doctor's work during delivery. Charles Meigs, a physician and one of the major vocal opponents to the use of routine obstetric anesthesia, described the diagnostic benefit of using pain to understand the different stages and progress of labor. While the advent of obstetric anesthesia meant that labor and birthing pain could be alleviated, it also gave physicians further authority and control over the patient's body and their experience of pain (Woods). Moreover, the focus and importance was placed on if anesthesia would be beneficial to medical practitioners, while the benefits to the laboring women was not a primary concern for physicians like Meigs. However, some physicians like James

Young Simpson—the discoverer of the anesthetic properties of chloroform and an advocate for the routine use of obstetric anesthesia—chastised physicians like Charles Meigs who let ““their medical prejudices... smother and overrule the common dictates of their profession, and of humanity.”” As the concern for the patient and their experience was not the central focus in the 19th-century medical discourse, this argument often had to be supplemented with the mention that obstetric anesthesia would also be beneficial to the doctor’s work (as the silent, unconscious patient was easier to work with and on), again emphasizing the improvement of the doctor’s work over concerns for the patient’s pain. By the 20th century, the humanitarian argument for reducing labor pain gained more traction and was sufficient enough to justify the use of obstetric anesthesia, but only for middle- and upper-class white women (Wood). Christian religious leaders and doctors with similar beliefs were also opposed to obstetric anesthesia due to Eve’s curse to labor in pain, as described in the Bible (Wood; Poovey 139-40). Many of the religious arguments asserted that labor had to be painful, thus to numb the pain through obstetric anesthesia would be sacrilegious and contrary to a woman's supposed maternal purpose.

The inferior social status and designated domestic expectations of women primed patriarchal society to both ignore and not believe women’s pain, especially within the medical fields of obstetrics and gynecology. For obstetric anesthesia, the limited cases when women’s pain was more believed and addressed was further restricted along racial and class lines. Women who were white, more educated, and of middle or higher class were deemed as more “civilized” and less “primitive,” and therefore more prone to feeling pain. Thus, there was greater successful advocacy for these women to receive and be entitled to obstetric anesthesia (Wood). These racist and eugenic ideas during this time also led practitioners like J. Marion Sims to conduct obstetric experiments on Black enslaved women without anesthesia. Though Sims also had white patients,

he only did these experiments on Black patients, and he only did them without anesthesia. Black enslaved women were seen as the ideal experimental subjects for white physicians because of unfounded beliefs that they could tolerate more pain and because the physicians saw them as inferior to white people. These racist ideas of pain tolerance still persist today, as women of color, and especially Black women, are less likely to receive adequate pain relief compared to their white counterparts. This is further motivated by stereotypes and stigmas of drug addiction in Black communities (Zhang). In one study looking at anticipated pain for IUD insertions, Black women were also found to have higher rates of anticipated pain (Hunter et al.), which could be linked to generational trauma and/or lived experiences of racist maltreatment by gynecologists. Moreover, women's pain in general is still ignored and not believed in many aspects of the medical field. There have been various instances of women's pain not being believed, and being much less believed than men's pain (Zhang). Female patients have also spoken about experiencing medical gaslighting about their health and pain, such as with women who were gaslighted by healthcare providers and had very traumatic childbirth experiences (Fielding-Singh and Dmowska). Furthermore, the doctor still maintains much of the authority over giving and describing pain management options for the patient, as seen with the lack of standardized pain management for IUD insertions. Even the IUD has a violent history, as its research and development was heavily supported and funded by organizations that advocated for eugenic population control. These white supremacist organizations saw the IUD as an easy and private way to effectively sterilize populations they deemed as not worthy of procreation (Corbett and Bautista), and thus contributed to the creation of more effective IUDs.

While female patients have been victims to many abuses in power by actors in the medical field, they have also made strides to take their healthcare into their own hands. For

several hundred years, women have advocated for their rights, including their health. Women led movements for health issues like obstetric anesthesia—such as with the suffragist and suffragette advocacy for a special drug cocktail called “twilight sleep”—and birth control (MacIvor Thompson). To be truly heard, the female patient has had to join forces with many other women with similar experiences to be taken seriously. With our current digital age, social media has become a vast site of collective action and outcry for women’s issues, and especially for issues of women’s health. The issue of pain during IUD insertions has received extensive engagement on social media platforms like TikTok, with many women recording and posting videos of their face contorting in pain and their cries of pain during the procedure. This patient advocacy sharing negative patient experiences serves to inform the public on the existing problems, and the support and engagement with the videos indicate that this is an issue that resonates with millions of members of the public. Though the TikTok algorithm curates users’ feeds according to their demographics and interests, and therefore users may not be seeking completely accurate educational or medical information from their feed, the immense popularity of videos with negative IUD insertion experiences and general distrust in medical care is indicative of larger issues in patient care (Wu et al.). There are a variety of reasons why people are engaging with these videos: they have personally experienced a painful IUD insertion; they resonate with and care about these issues, possibly because they or someone they know has experienced something similar; they have a distrust in gynecology and the medical field due to historical and current abuses of power and care; they personally did not have intense pain, and therefore are either advocating for pain relief for those who need it or see this as a non-issue or an issue for just a small minority; they generally want to discount or express their disbelief in the patient’s pain; or they may be practitioners, researchers, or other biomedical actors that recognize the patient’s

pain but describe this experience of pain as relatively uncommon, or support the calls for better pain management. Regardless of exactly why the public engaged with these videos, it is clear that they had an impact and caught people's attention in some way. Moreover, the social media outcry led many other media outlets, medical journals, and medical organizations to report on these issues, demonstrating its widespread impact in highlighting and legitimizing the pain of IUD insertions. This increased reporting was also a signal to the medical field on the importance of addressing patient concerns before, during, and after medical care, as this content likely contributes to a more negative view of IUDs and of medical practice. In a significant victory, the patient advocacy and media outrage by reporters, patients, researchers and practitioners also led to the CDC updating their 2016 practice recommendations for IUDs after 8 years, incorporating more information about pain management options and emphasizing the need for discussing pain management with patients.

Though patients and practitioners both contributed to the legitimization of IUD insertion pain, there still are major gaps in the practitioner and patient perspectives that need to be addressed. With the high media engagement on painful IUD insertions, many practitioners felt the need to speak out about the safety and efficacy of IUDs. Furthermore, they emphasized that this pain is not experienced by the majority of patients they see (though it is unclear how exactly they are collecting this data on their patients' pain). As many previous IUD patients have been parous (and therefore tend to experience less pain) and practitioners have been shown to underestimate patient's pain during the IUD insertion procedure, these generalizing statements can discount the real pain both parous and nulliparous women are experiencing. While it is understandable for practitioners to want to do "damage control" for a very safe and effective method of contraception—trying to improve the reputation of IUDs in the public eye, so to

speak—labeling this pain as uncommon dismisses many women’s pain and can further mislead patients. Moreover, prospective IUD users may focus on or be scared by even a single person’s negative IUD experience, and thus need their concerns and anxieties addressed rather than dismissed. The practitioner and patient perspectives ultimately represent the difference between being the person inserting the safe and effective IUD versus being the person having a potentially painful IUD insertion. These are very different things, so practicing empathy, having open conversations, and creating safe spaces for patients to share their concerns can help to narrow these gaps in patient-practitioner communication and understanding.

The fight for the legitimization of IUD insertion pain was and continues to be led by patient advocacy, but was and continues to be validated and solidified by medical practitioners, biomedical researchers, and medical institutions like the CDC. The path to legitimization represents the hierarchical structure of the U.S. healthcare system and its medicalization of pain. IUD patients (and patients in general) rely on their practitioners for pain relief, who in turn rely on the research and official medical guidelines to offer and administer pain relief. Yet, this reliance becomes problematic during the in-between, when patients are feeling real pain but their pain is not being legitimized or addressed by their physicians because the evidence does not support it. It is insufficient to not acknowledge or address patient pain just because the evidence is not conclusive enough. Perhaps prior to the advent of pain relief this approach would have been a little more conceivable. But when safe options for pain relief exist, there needs to be a stronger effort to offer and use them, instead of letting women suffer through their pain until there is enough of a collective outcry. Practitioners need to consistently check in with the patient to ensure their comfort before, during and after the procedure. Furthermore, even if the research and their training described the IUD insertion as “a little pinch,” it is necessary for all medical

practitioners to listen to and believe their patient's pain. This is especially necessary with the sensitive nature of gynecologic and obstetric procedures, as past trauma, historical neglect, and disregard for women's pain have impacted patients' trust and comfort with receiving healthcare. Though there has been a lot of progress made in the legitimization of IUD insertion pain—going from primarily describing it as “a little pinch” to creating official clinical guidelines on shared decision-making for pain management—there is a need for more comprehensive research on the most effective methods of pain relief and for a systematic review confirming the implementation of these changes in medical practice.

Through the remaining chapters of my thesis, I will explore patient and practitioner perspectives to better understand exactly how IUD insertion pain has been legitimized in recent years, and the ways in which it still needs to be legitimized.

Part I: Thematic Analysis of IUD Patient Perspectives on Pain

Introduction to the Research Study and Thematic Analysis

Among the research literature on IUD insertions and pain, there has been a significant absence of in-depth patient perspectives. While most studies are centered on patients' quantitative evaluations (such as ratings from 0-10) or other similar evaluations of the pain, what gets lost in this general characterization is the context, variability, and details that make up the whole of the IUD insertion experience (including experiences of pain post-insertion, as the body is still adjusting to the insertion of the IUD). Pain is also very subjective and can be more holistically studied using a qualitative approach. By conducting a research study focused on patients' personal descriptions of their IUD insertion, I aim to humanize patients' pain and provide a more comprehensive understanding of their perspectives and experiences regarding their IUD insertion. Ultimately, my main research question is to describe and understand how patients characterize their IUD insertion experience with regards to pain and where they see gaps in care.

This research study (approved by the Barnard College Institutional Review Board) involved interviewing nulliparous women who had an IUD insertion within the past 3–4 years to evaluate the impact of recent efforts to legitimize IUD insertion pain. I chose to focus my patient population on nulliparous women as previous studies have not always accounted for the differences between multiparous and nulliparous patient experiences of pain in IUD insertions. Moreover, as evidence has shown that nulliparous women have a higher incidence of pain during IUD insertions, addressing pain in this population can pave the way for better pain management for all IUD patients, regardless of parity. While this research study will focus on nulliparous

women, future research should also aim to include both patient populations as well to ensure pain can be adequately addressed for all relevant populations.

I employed a thematic analysis approach to analyze the interview data, roughly based on the approach outlined in “Practical thematic analysis: a guide for multidisciplinary health services research teams engaging in qualitative analysis” by Saunders et. al. The method of thematic analysis I used involves iteratively reading through each individual interview to identify codes (i.e. labels for key concepts, ideas, patterns, and/or relationships present in the data), and then connecting and grouping similar codes to identify broader themes present across the data. Some of the notable differences between my approach and the article’s recommendations are the absence of collaborative analysis by a research team (I conducted the analysis on my own, which is a potential limitation of my study) and a smaller sample size to achieve data saturation. Data saturation is “the point in analysis at which new data tends to be redundant of data already collected” (Saunders et. al). The article defines the general marker for data saturation as 9-17 interviews, yet also explains that this can vary depending on the study. My sample size of 5 patients provided enough data to identify a wide variety of codes and themes, while ensuring that there were enough redundancies between all the patients’ perspectives to achieve data saturation. While conducting more interviews would have helped to better confirm data saturation, I was still able to achieve appropriate data saturation to meet the goals of my study. My aim was not to provide a comprehensive, exhaustive data set through this research, but rather to highlight the major areas and concerns present in patient perspectives that medical professionals and future research studies should keep in mind and aim to address. In formatting the presentation of my thematic analysis results, I drew inspiration from the Saunders et. al article and the DeForge et. al

article, “Medical Decision-Making and Bereavement Experiences After Cardiac Arrest: Qualitative Insights From Surrogates.”

To contextualize the experiences of patients within the context of the medical establishment as a whole, I follow the “Hear from the Patients: Perspectives on their IUD Insertions” section with Part II, “Perspectives and Players Within the Field of Gynecology.” In this chapter, I expand on the main findings from my interviews with an OB/GYN and OB/GYN resident about their experiences and perspectives on pain in IUD insertions, discuss medical training on IUD insertions, consider the role of sedation and anesthesia in preventing IUD insertion pain, and conduct a brief exploration of some of the existing literature and guidelines on IUD insertion pain from medical organizations such as the CDC and American Journal of Obstetrics and Gynecology (AJOG).

Through this research, I ultimately aim to provide suggestions for how medical practitioners and actors can improve patient experiences during the IUD insertion procedure. I will also highlight where there are still research gaps in the legitimization of pain and the understanding of pain management in IUD insertions and share recommendations for future research.

Hear from the Patients: Perspectives on their IUD Insertions

To better understand patient perspectives and experiences of IUD insertion, I interviewed¹ patients on 4 main questions: what they knew and how they felt about IUD insertion pain prior to the procedure; how they describe and characterize their experience of the insertion and post-insertion pain; how they felt about the handling of their IUD insertion pain² and pain management; and what they believe would have made their experience better. I interviewed 5 nulliparous patients for a total of 6 interviews (one patient had 2 separate IUD insertions within the past 4 years). In *Table 1*, I have provided general information for each patient. To humanize and properly introduce each of the patients prior to the thematic analysis, I have also summarized some of the major aspects and moments in each patient's experience of getting their IUD below.

¹ The full list of patient interview questions can be found in Appendix A (p. 74).

² Experiences of pain during IUD removal were also included when applicable, as there are relevant overlaps between IUD insertion and removal. However, the thematic analysis does not include data about IUD removals.

Table 1*Overview of Nulliparous Patients Interviewed*

Patient Name*	Type of IUD	Date of Insertion	Type of Clinic	Clinician Performing Insertion	Pain Management Used
<i>Meera</i>	Copper (Paragard)	April 2022	Planned Parenthood, Lower Manhattan	Physician Assistant or Nurse Practitioner	None
<i>Ari</i>	Copper (Paragard)	October 2024	Barnard College Primary Care Health Service	Nurse Practitioner	Acetaminophen; anxiety-reducing measures
<i>Shayla</i>	Hormonal (Mirena)	December 2024	Harvard Vanguard / Atrius Health (Private healthcare offices)	Gynecologist (with a Medical Assistant)	Misoprostol; Lidocaine injection in the arm
<i>Jade</i>	Hormonal (Mirena)	May 2021	A Private Gynecologist Office in Southwestern Florida	Gynecologist	Ibuprofen
	Hormonal (Mirena)	March 2025**	Barnard College Primary Care Health Service	Nurse Practitioner	Ibuprofen; anxiety-reducing measures
<i>Liana</i> [†]	Hormonal (Mirena)	December 2024 [†]	Major hospital system in Portland, Maine	Gynecologist	General anesthesia ^x

* Arbitrary names have been used for each patient.

** The IUD from May 2021 was removed in the same appointment as the March 2025 insertion.

[†] This IUD was removed in the first week of January 2025.

^{† †} The patient had previously received an IUD around 20 years ago, but had it removed due to an associated stabbing-like pain (patient felt the IUD was not placed correctly).

^x The patient was under general anesthesia because she was concurrently receiving a D&C procedure.

Summarized Patient Experiences

Meera

“The worst pain I’ve ever felt in my life...I didn’t have a point of reference...I remember blacking out and I almost threw up, because it was just so intense.”

Meera’s IUD insertion experience was incredibly painful. While she had previously heard about the possibility of pain during her insertion from friends and through online research, she was not informed on the potential options for pain management by the medical practitioner. When Meera was visibly in pain and nauseous during the procedure, the practitioner gave her an ice pack on her head, water, and snacks to prevent fainting. Though Meera appreciated the practitioner’s efforts to make her comfortable, she felt that there was nothing that could help her pain other than an effective anesthetic or other form of pain management. In the days following her insertion, she also felt cramping and soreness near the insertion site.

Two years after the insertion, Meera began to have gynecologic issues and continuous menstrual bleeding that she suspected were caused by her IUD. Approximately 2.5 years after her insertion, Meera decided to have her IUD removed with her gynecologist from home. Meera described feeling significantly more anxious for the removal than she had been for the insertion, but the removal went much more smoothly and painlessly than her insertion. During the appointment, her gynecologist explained that her IUD had fallen out of place, which may have been the cause for her symptoms. Meera has since switched to using hormonal birth control pills for contraception, as they also address some of her other health issues. Nonetheless, she would not consider getting another IUD unless there were better pain management options offered.

Ari

“They did not use the anesthesia, so, definitely felt everything [small laugh]. But it was maybe like a minute of intense, uncomfortable pain. Which was less time than I had anticipated, but it hurt more than I thought it would.”

Ari had heard a little about the pain associated with IUD insertion from the internet but was mostly concerned about recovery, particularly because the copper IUD is known to cause more bleeding and cramping. Prior to the IUD insertion, she had to schedule a mandatory consultation appointment about birth control options before the IUD could be ordered. Potential pain was not discussed as a part of this appointment.

At her IUD insertion appointment, the nurse practitioner walked Ari through the procedure in a lot of detail so that she knew exactly what would happen and how long each step would last. Ari appreciated that there were no surprises and found it helpful to have this information before the insertion began. Another medical staff member also joined Ari for the insertion (serving as an IUD doula), giving Ari her hand to squeeze if she needed it and providing emotional support. To make her feel more comfortable and reduce any potential anxiety, Ari was also given an aromatherapy sticker on her shirt and the option to play the song of her choice during the insertion. Ari also described that having previously been to the gynecologist for a pap smear made her relatively more familiar and comfortable with the orientation of her body during the IUD insertion procedure.

While these efforts were appreciated, they did not address the pain at the time of insertion. Ari did not recall feeling anxious about the insertion procedure until right before the

physical insertion, when she had the internal realization that it was really going to hurt. She described the insertion as a very intense, uncomfortable pain, but was surprised by how fast it was over. The actual insertion felt about 1 minute long, and hurt more than she expected, but immediately after she did not feel any pain and felt comfortable with the IUD in. Ari was again advised to take acetaminophen for post-insertion cramps.

Although Ari was overall satisfied with her IUD and did not regret getting it, she wished that local anesthesia had been used and believes it should be standard practice. While she did not initially question the clinic's lack of anesthesia—partly because, as a future OB/GYN, she wanted to understand what the procedure feels like without anesthesia—she would recommend that others seek out clinics that offer anesthetic options to improve the insertion experience.

Shayla

“The insertion itself, it really wasn't as bad as I thought it was going to be. It was manageable. I will say the most uncomfortable part was when they had put the speculum in...And then when she did the actual IUD, it felt like cramping...but it wasn't as bad as, you know, my period cramps...It still wasn't pleasant.”

Prior to getting an IUD, Shayla had been on birth control pills to address her incredibly painful and nausea-inducing period cramps. While the pills helped her cramps, they made her nausea worse. When Shayla went to the gynecologist for help with the nausea, her gynecologist recommended that she switch to using a hormonal IUD. Though there was availability to get the IUD the next day, Shayla needed more time to mentally prepare. She had heard so many different stories about pain during IUD insertions, and her own sister had had a very bad IUD insertion

experience. The stories of negative IUD insertion experiences especially stuck with her and made her relatively anxious for her IUD insertion scheduled for a few weeks later.

In the initial consultation appointment, the gynecologist explained that she would give Shayla misoprostol to help open up her cervix, especially because she was nulliparous. Furthermore, she said if Shayla was feeling a little more anxious about pain, she could come 30 minutes before her appointment to take a local numbing injection (most likely lidocaine). Her gynecologist reassured her that the combination of these 2 interventions should make the pain more manageable during the insertion.

Shayla was most concerned about feeling awful after taking the misoprostol as a common side effect is nausea. Nonetheless, she took the recommended dose the night prior to and the morning of her insertion and came in early to get the injection. Shayla was given the option to get the injection in her arm or her buttock. Though it was described to be more effective when taken in her buttock as it is physically closer to her cervix and uterus, she was more comfortable with getting the shot with her arm. She was also given the option to play the song of her choice (“One of These Nights” by The Eagles) during the IUD insertion.

Though Shayla’s IUD insertion finished before the 3-minute song was over, she described that the insertion felt longer as she was quite nervous. The most uncomfortable part was the speculum insertion, which felt like a burning sensation similar to putting in a dry tampon. The actual insertion of the IUD insertion felt like cramping, which was uncomfortable but not as bad as her typical period cramps. Shayla was not sure if the injection helped with the IUD insertion, but was satisfied with the misoprostol, especially as she had not experienced any nausea.

Compared to others she knows, Shayla felt she had a good experience. However, she recognized that she had a certain level of privilege in the care received as her aunt (a

gynecologist) was able to address some of Shayla's concerns privately, the gynecologist who did the IUD insertion was her aunt's friend and therefore might have been extra careful, and her mom was able to drive her home after her appointment, allowing her to relax post-insertion.

Though Shayla was overall satisfied with her insertion experience, she would have appreciated more verbal hand holding from her gynecologist about what was going to happen during each step before it actually happened.

Jade

1st IUD Insertion

“The entire thing was uncomfortable, but I think I was just breathing, and I was just like, okay, there's nowhere, there's no other option for me right now... This is how it is. I just have to do it... so, yeah, it was pretty painful... I don't think I cried. I think, like, a tear came down, just a tear of pain.”

Jade did not feel very concerned or anxious before her IUD insertion, which was also her first ever gynecologist appointment. Before the appointment, Jade was instructed to take ibuprofen. At the start of the visit, her gynecologist consulted Jade and briefly explained that she would experience some cramping during the insertion.

The first moment of significant discomfort for Jade was the insertion of the speculum, which remained uncomfortable throughout the whole procedure. To manage the pain, Jade kept focusing on breathing and mentally telling herself that she just had to get through it. The gynecologist was having some trouble opening the cervix and had to call another doctor in to help. Once they solved the issue, Jade felt a big cramp. She exclaimed that it hurt, and the

gynecologist tried to be reassuring, affirming the pain Jade was feeling and telling her to keep taking deep breaths. Jade described the insertion as quite painful, but that it was over quickly.

After the insertion, Jade drove herself home and rested. She experienced cramps and soreness, which she managed with ibuprofen and a hot compress. However, none of the post-insertion cramps were close to the cramps she felt during the insertion.

Jade was overall satisfied with her insertion experience as she did not have any complications after the insertion. During the insertion, being told that she was going to feel a cramp right before she actually cramped helped to make it bearable. In Jade's mind she knew there were a limited number of times the cramping pain would happen, which helped her get through it. However, Jade found the moment when the doctors were struggling to open the cervix difficult to manage, as she did not know how much longer the insertion would take and if they would even be able to do it. Yet, she still trusted her doctors and was not significantly worried at any point during the insertion. Though she felt her gynecologist generally did a good job, she also did not know what more could have been done in terms of pain management and improving the overall experience.

2nd IUD Insertion

"I was expecting it to be bad or something...especially when I found out they have an [IUD] doula. I was like, oh my god, it's gonna be bad. And the actual thing was actually super smooth. To be fair, she was like this is a textbook insertion, this went extremely well... Yeah, it was extremely quick and good vibes."

Jade received her second IUD in a different clinic and had a very different IUD insertion experience. Though her original IUD was still effective as a contraceptive for a few more years, she chose to get it removed and get a new one. Hormonal IUDs can lighten periods, especially during the first few years of having it. However, after having her IUD for about 3 years, Jade's periods had returned to their pre-IUD state. Thus, to lighten her period again, she decided to get a new hormonal IUD. Furthermore, she still had health insurance through her college and wanted to replace her IUD while it was still covered by insurance.

This clinic also told Jade to take ibuprofen before, but that was essentially where the similarities to her previous experience stopped. Jade felt a little more anxious for her insertion this time because she found out there would be a medical staff member serving as her IUD doula. To Jade, the inclusion of an IUD doula indicated that the insertion process would be bad as it involved an external emotional support person. Jade was a little concerned that this intervention might make her think about the pain more.

Prior to the insertion, Jade was provided with an aromatherapy sticker, the option to play music, and a heating pad. Jade really appreciated all these pain management techniques, as even if they did not directly prevent pain, they helped to give her something else to focus on during the insertion. Throughout the insertion, the nurse practitioner was very specific about telling Jade what was happening as it was happening (more than her previous insertion). Jade liked knowing exactly what was going to happen and liked that there was nothing unexpected. Immediately after the insertion, she was also given Gatorade, which she appreciated. Collectively, Jade felt that the clinic's approaches helped to reduce her anxiety and experience of pain.

Jade found that her IUD removal and insertion both went super smooth at this clinic. The gynecologist did say that Jade had a textbook insertion and it went extremely well, especially

compared to the complications she had during her previous insertion. Jade strongly preferred her second insertion experience over her first one, as it was less painful and much more straightforward and comfortable.

Liana

“Basically, what she had said is my body just kind of rejected the IUD, and so I had such, just kind of a really, really raging infection in my body...it was one of the most painful things ever to have it taken out just because of them having to, like, put equipment inside of you when you're already in just tremendous amounts of pain.”

Liana is a menopausal woman whose gynecologist recommended a hormonal IUD to help treat her simple uterine hyperplasia (which is a pre-cancer cell). As she had elevated liver enzymes, the hormonal IUD was recommended over other forms of hormonal birth control to bypass her liver while still thinning her uterine lining. With the discovery of a benign polyp, Liana’s gynecologist also wanted to do a D&C (a surgical procedure involving the removal of tissue from inside the uterus) to test the rest of the uterine lining. Though her gynecologist said the D&C could be done with local anesthesia, Liana insisted on going under general anesthesia to prevent an unnecessarily painful and uncomfortable experience. Thus, Liana received the D&C and IUD insertion in the same office visit under general anesthesia.

Liana was most concerned about how she would react to the hormonal IUD, as she had had strong emotion changes from birth control pills and bioidentical hormones with testosterone in the past. She was especially fearful of having something permanent in her body that she could not easily remove. Though she had previously gotten an IUD for contraception around 20 years

ago, she got it removed within a week due to pain that she associated with an incorrect placement of the IUD. Nonetheless, she trusted her gynecologist's judgement and decided to take a chance on the IUD to bypass the liver, prevent taking pills (as Liana is not great with taking medicine), and have a preventative measure that she would not have to worry about. Furthermore, her gynecologist reassured her that if the IUD was not working for her at any point, she could get it removed.

Liana recalls that the anesthesia went fine and that she felt a lot of pain after she woke up, mostly because of the D&C. While she was recovering, she also felt a lot of pain. During a long, stressful road trip where she drove from Maine to Indiana for the holidays (about 2 weeks after the procedure), she experienced significant period cramps and what felt like intestinal pain. Overall, she felt like something was not right, so she met with her primary care physician (PCP).

Liana's PCP told her that the IUD was likely causing infection and inflammation and that she should get it removed. At this point, Liana had also been experiencing strong emotions of sadness, irritability, and feeling overwhelmed, likely associated with her reaction to the IUD hormones. She scheduled an urgent appointment with her gynecologist, as she felt that she just needed to get the IUD out. Liana described that while the pain was there, her most urgent reason for getting the IUD removed was due to the significant negative impact it had on her mood.

At her gynecologist appointment, Liana learned that her body was essentially rejecting her IUD, which had caused a really bad infection. She described that the IUD removal was one of the worst pains she had ever experienced because her vaginal canal was very infected and inflamed. Liana was then put on UTI meds and a strong cocktail of antibiotics to treat the infection. The antibiotics were hard on her kidneys and stomach, but she could feel the intestinal pain starting to go away after about a week. Liana was then given an insertable cream antibiotic,

but that gave her painful cysts down her inner thighs and slightly on her back. She used topical lidocaine to help numb the pain for an hour at a time, and with time the cysts went away. The antibiotics had also significantly reduced Liana's immune system's defenses, which led to her getting one strain of the flu, and then a second strain of the flu. She had to go to the hospital a few times to get fluids. Liana also ended up getting the norovirus and was hospitalized for a few days as a result. Though Liana started to feel better soon after, she described the whole experience as traumatic and stated that it forever changed the way she thought about illness and her body.

When asked what changes she would have preferred in her IUD insertion experience, Liana said that she simply would not have gotten it. Her body reacted very strongly to the IUD in a variety of ways, and she would have avoided a lot of pain, sadness, and sickness if she had just never gotten an IUD inserted. Liana's body really just did not agree with the insertion of an IUD.

Though Liana's IUD insertion experience was traumatic, she really trusts and appreciates her gynecologist, who she describes as very compassionate and phenomenal. She recognized that her negative IUD insertion experience was due to her body's reaction to the IUD more than any other factor. However, one thing she wishes could have been done was for some form of pain management to be offered during the IUD removal. She believes that her gynecologist should have seen that the vaginal canal was very infected and inflamed but might not have realized how painful the removal would feel as a result.

Beyond her own experience, Liana's D&C and IUD insertion and removal experience made her generally frustrated about how women's bodies are treated, as she believes neither procedure includes enough pain management for patients to have a less painful and more comfortable healthcare experience.

Thematic Analysis

All patients experienced pain during and/or related to their IUD insertion. However, there was great variability in how they defined their pain, from manageable to the worst pain of their life. Through analysis of the interview data, 6 major themes were identified and sub-categorized as necessary. While each theme explores different aspects of the IUD insertion experience, they are by no means mutually exclusive from one another. In discussing each theme, I have drawn insights from the patients and existing research and have provided suggestions for best practice where relevant. A summarized table of the interview transcripts and codes that were used to identify the themes can be found in Appendix B (p. 76).

Theme 1: Anxiety and concern about pain before the IUD insertion

Patients were overall concerned about the pain of getting an IUD insertion, though they had varying levels of anxiety. Moreover, patients felt anxiety at different moments: some felt it in the days leading up to the insertion, others right before the insertion, some in the post-insertion recovery, while others were generally not concerned and/or unaware about the potential pain.

Subtheme 1: Hearing stories about other patients' IUD insertions

Most patients were aware of the pain during IUD insertions through stories they heard from friends, family, and/or online sources. While the stories ranged in severity of pain, from mild pain and discomfort to unimaginable pain, patients described that the negative stories they had heard were in the forefront of their minds going into their insertion. Thus, even one bad IUD insertion story was enough to contribute to patient anxiety, regardless of the other good insertion stories they might have heard before.

Subtheme 2: Appreciation for anxiety-reducing methods and interventions

Various non-pharmacological methods of pain management were provided in some of the patients' IUD insertion experiences, such as a(n) heating pad, aromatherapy sticker, music of choice, electrolyte drink, snack, and/or an IUD doula. Patients also described that the medical practitioner's use of clear communication, validation of pain, and encouragement to practice deep breathing also helped to address their anxiety and manage their pain.

Patients appreciated these methods to make them feel more comfortable and familiar with the IUD insertion procedure and the office space itself, and to overall reduce their anxiety about the procedure. These methods were also characterized as helpful because they gave patients something else to focus on and think about during the procedure other than their anxiety about potential pain, or their actual experience of pain.

While patients appreciated the efforts to help reduce their anxiety, manage their pain, and make the whole experience more bearable, they also emphasized that these interventions did not directly address the physical pain of the procedure. Patients felt that all the benefits these methods provided became largely irrelevant during any moments of intense physical pain.

For patients, the whole IUD insertion experience was bettered by these efforts to make them feel more comfortable and familiar with the procedure. Yet, they described that the pain associated with the actual insertion of the IUD requires a more effective, likely pharmacological, intervention.

Theme 2: The necessity of being informed

Patients view being informed on the IUD insertion procedure as knowing what will be done to their bodies. Though the medical practitioner may be the one who needs to know the technical aspects of the procedure, the patient is equally if not more so involved in the procedure and should therefore be adequately informed. The desire to know more about the procedure is a

clear and sensible ask, especially as patients are the subjects of the medical procedure. Even when not asked, it is the role of the practitioner to ensure the patient is properly informed on and aware of the relevant aspects of the procedure, especially as it relates to pain management options, the potential pain of the procedure, and what is being done to the patient's body at each step.

Subtheme 1: Consultations on pain management options

As patients had varying levels of understanding about the pain management options available to them for IUD insertions, practitioners should prioritize giving a detailed consultation on the methods available for pain management. Many of the patients interviewed did not know about pain management options available beyond over-the-counter pain medication. Though the data is not conclusive on the most effective pharmacological pain management interventions, there are various options (both pharmacological and non-) that could help patients feel more comfortable and could prevent an unnecessarily painful experience. As was the case for Shayla, her gynecologist recommended getting a general numbing shot if she was feeling more anxious about the IUD insertion. This recommendation indicates that the numbing shot might not be entirely effective for reducing IUD insertion pain (at least according to existing research), but evidence does support its safety. As increased levels of anxiety have been linked to higher reported pain levels in IUD insertions (Rahman et al.), addressing anxiety in this way can prevent a more harmful, painful IUD insertion experience. Moreover, there is also the possibility that the pain management method used might actually help reduce and/or numb the experience of pain during the procedure. Patients would therefore appreciate the medical practitioner to inform them on the pain management options available for the IUD insertion procedure (and associated pros and cons), even if their clinic does not offer them. If the clinic does not offer the pain

management the patient is interested in receiving, patients can then find another clinic that can serve their individual needs. While this may not always be an option for patients due to financial constraints and insurance coverage, all patients still have the right to be informed on the pain management options. Ultimately, being informed on their options can give patients additional agency and control over their IUD insertion and their healthcare in general.

For patients who are somewhat aware of other pain management options, such as local anesthesia, their main confusion is why these methods of pain management are not as widely used. From a historical standpoint, there has been and still continues to be medical gaslighting about the inability to feel pain in the cervix. This has contributed to a historical inadequacy of research on effective pain management for procedures involving the cervix, which is also partly why there is not very clear, conclusive evidence to support any method of pain management for IUD insertions. Thus, it is important for practitioners to not only explain the options available to patients but also explain the relative efficacies and potential side effects of each option. While more research is being done to identify the most effective pain management method, practitioners must continue working with patients to identify which available method they would most prefer.

Subtheme 2: Knowing what is being done to one's body throughout the procedure

Gynecologic procedures place patients in a very vulnerable position and involve dealing with more sensitive areas of the body. Though all medical procedures involve bodily vulnerability to a certain extent, gynecologic procedures should especially involve in-depth informed consent. Shayla, for example, described that she did not always know exactly what was happening or what was being done during each step, and overall felt that the steps were not made very clear before and/or during the procedure. IUD insertion patients want clarity on what is

being done to their bodies. Patients like Ari and Jade (during her second insertion) who received more clarity at each step of the procedure, really appreciated knowing what was happening and liked that there were no surprises.

Jade, who had 2 different IUD insertion experiences, recalled that it was difficult to manage when the doctors were having difficulty during her first IUD insertion. Being in the dark about the actual difficulty, what is being done, and simply having one's body talked about as if they are not an active part of the procedure is both disrespectful and potentially traumatizing. Especially in situations of difficulty, physicians need to be as clear as possible about what is going on and what they are trying to do to figure out the next steps.

Not having clear information about the practitioner's actions on the patient's body, especially when the patient's body is in a vulnerable position, can be very traumatic and painful. Patients characterized that being informed at each step of the process is necessary for a better IUD insertion experience.

Subtheme 3: Clearer, more objective language about the IUD insertion steps

In describing the negative sensations patients might experience during an IUD insertion, practitioners tend to use blanket words like discomfort or pain. Patients indicated dislike for this vague language and instead indicated preference for more in-depth description of what was going to happen in each step. Research also suggests that the use of language with more negative connotations or that cause an increased anticipation of discomfort, such as, "You are going to feel a lot of pressure" or "This will feel very uncomfortable" can increase patients' perceived pain. Thus, using more objective language, such as "I am now going to introduce the speculum" or "I will now open the speculum," avoids negative priming on the stimuli, reduces anxiety about any potential, impending pain, and clearly informs the patient on what is going to happen

(Carugno et al.). In Jade's second insertion, she described that the practitioner used language such as, "I am going to tap 2 times, on the first tap I will insert the speculum, and on the second tap I will open it." This type of communication is also objective and was found to be helpful for the patient. While the goal should also be to actually reduce the discomfort and pain associated with the different tools and steps, the use of more clear, objective language can prevent a more painful IUD insertion procedure.

Theme 3: There is no other option but to push through the pain

During their IUD insertion, many patients felt that they simply had to endure the pain and deal with it, that there was no other alternative. While they felt frustrated that there was no better alternative given to them, they also described a kind of reluctant acceptance of the pain that they would have to experience to get the healthcare they wanted. In the moments of pain, patients were told to continue taking deep breaths, and they did not feel there was much else to be done for their pain.

This idea of having to push through pain is linked to how women's bodies have been historically treated within gynecology and healthcare in general. However, practitioners and the field of gynecology should do everything in their power to reverse this narrative. When patients believe the pain they experience during these procedures is inevitable, they are less likely to vocalize their discomfort, and issues of pain management receive less attention. Practitioners should emphasize the importance of patients feeling comfortable and safe, maintaining control over their bodies and the procedure, and being able to openly communicate the need for a break or to stop the procedure altogether. In addition, as previously mentioned, a thorough consultation on pain management options can reinforce the message that patients should not have to endure unnecessary pain and suffering. These conversations should form the foundation of every

gynecologic procedure, with practitioners working alongside patients to build trust, establish effective methods of communication—especially during moments of physical pain when verbal language may not be accessible—and equip patients with the tools to actively control their IUD insertion experience.

Theme 4: Regretting the IUD during experiences of intense pain

In moments of peak pain during and after the IUD insertion procedure, patients felt regret about choosing to get an IUD. If the pain ultimately resolved, patients became satisfied with their decision to get an IUD. However, if the pain or any negative reactions to the IUD did not get resolved until IUD removal, patients were not satisfied and often wished they never got an IUD. This phenomenon, though perhaps self-explanatory, highlights how patients will think about the pain of their IUD insertion experiences and how they decide if it is worth it. Since IUDs are very effective and low-maintenance, patients sometimes view the pain as a necessary trade-off for the benefits. However, this mindset can also influence practitioners' way of thinking about the pain, which is problematic because they must focus on advocating for and seeking better methods of pain management.

Theme 5: Recognition of differences between individual patient experiences

All the patients' IUD insertion experiences varied in different ways, and all the patients recognized that their experience may be similar to others, or not at all. Furthermore, most patients had different methods of pain management used, which impacted their overall experience of pain. Regardless of their individual experience of pain, patients all uniformly advocated for and supported better pain management for IUD insertions.

Subtheme 1: Estimations and expectations of pain

Based on previous knowledge or lack of knowledge about the potential for pain during IUD insertions, patients had different expectations for how painful the procedure was going to be. Some patients found the pain to be much worse than they expected, while others overestimated the amount of pain they would feel. This was often linked to the stories they had heard before, as those who had not heard many IUD insertion stories or had not heard many stories that included suffering and/or pain tended to have lower expectations for pain, while those who had heard more stories of suffering and/or pain tended to overestimate the pain they would feel. Proximity to the storyteller may have also influenced how much the story impacted each individual, as hearing about a close friend or sister who went through a painful IUD insertion can have more of an impact on expectations of pain than a random stranger's experience of pain.

Meera, who felt her practitioner underestimated the pain in her descriptions of the procedure, was not sure if the underestimation was helpful or not. While she understood that practitioners might try to underestimate the pain to not scare the patient, she also did not like being surprised by the intensity of the pain. However, it might also be true that the practitioner was not purposely underestimating the pain, but rather that practitioners cannot always predict how individual patients might react to or how much pain they will feel during an IUD insertion.

Shayla—who had higher expectations for pain during her insertion because she had heard more negative stories about it—was told by her gynecologist that she would have relatively lower pain during the insertion because of the pain management she was going to be given (though the gynecologist did emphasize the potential for nausea and other side effects due to it). Shayla described her insertion pain as not as bad as she was expecting, which likely had to do with the pain management she was given. She also described that the cramping she experienced during the insertion was much less painful than her normal period cramps. Thus, her frame of

reference for the pain made her expect more pain than she actually experienced. Furthermore, she did not have negative side effects from the pain management, which gave her additional relief.

While there is no one right way to give estimations or expectations of pain, as every patient is different, practitioners should not use any language that defines the pain of IUD insertions as one way or the other. Setting up certain expectations can be harmful, especially if the patient's experience is worse than what they were told. The potential for pain should definitely be discussed, especially as it correlates to different aspects of the procedure, but strong emphasis should be given to the pain management options and the patient's control over the procedure.

Subtheme 2: The peak-end rule for pain in IUD insertions

The peak-end rule is a psychological concept that defines how people tend to retroactively characterize an experience according to the worst moment and the final moment (Fredrickson and Kahneman). When applied to the IUD insertion experience, the peak-end rule demonstrates how patients define their IUD insertion experience in terms of the moment of peak pain during their IUD insertion and the end of their IUD insertion experience (whenever they may define that to be). The patients' characterizations of their IUD insertions followed the peak-end rule, as their overall experience was defined by the trajectory of pain during the insertion and post-insertion experience. If their pain was really intense at the moment of insertion (the peak), but their recovery was overall good (the end), they characterized the insertion as painful but that they were overall happy with their IUD insertion. If the patient had intense pain during their insertion (the peak) and either their recovery was bad or they had negative-symptoms related to their IUD and therefore got it removed (the end), they were not

happy with their IUD insertion. Thus, reducing pain at all points, not just during the insertion but also during the post-insertion recovery period, and working to understand and address the patient's negative bodily reactions to their IUD as soon as they are known can improve their healthcare experience.

Theme 6: The role of the practitioner

As it was discussed in relation to every theme, the role of the practitioner is a vital aspect of the IUD insertion experience. Patients described that being able to trust and feel comfortable with their practitioner greatly impacted how they felt about their whole experience. Even for patients who had very painful IUD insertion experiences, the presence of a compassionate provider who recognized, validated and tried to address their pain and suffering was incredibly helpful and important.

Most patients did not blame their individual practitioners for inadequate pain management options but still recognized that the practitioner had an important role to play in making IUD insertions less painful. The responsibility to initiate consultations and conversations on pain management options, as well as how patients prefer to communicate their pain (especially if it may be hard to talk while experiencing intense pain), request a break, or stop the procedure, all fall to the practitioner. Moreover, practitioners should be especially aware of the increased potential for pain with nulliparous patients and should consult accordingly. While the patient can of course also initiate these conversations, it is the job of the practitioner to make sure these conversations are had. Ultimately, it is also up to each individual patient what they would like their practitioner to do. This is also why having open conversations about expectations of care and concerns about the procedure should be an integral part of every IUD insertion appointment.

Irrespective of the pain during their IUD insertion experiences, all the patients indicated that their experience did not negatively impact their relationship with the field of gynecology or dissuade them from ever going to a gynecologist again. Part of the reason for this might be because even if their experience was not ideal, their practitioner did not make the experience more traumatic by dismissing their pain. Having their pain legitimized in this way was very important for patients and for their relationship to gynecology as a whole. The next step in legitimization, however, is for practitioners to continue advocating for and supporting efforts to find more effective methods of pain management.

Recommendations for Gynecologic Practice and Future Research

Some of the key patient populations and focus areas absent from this thematic analysis research include: patients who received different pain management methods (e.g. paracervical blocks, topical lidocaine, ultrasound-guided insertion, etc.); patients who had previously traumatic gynecologic or sexual experiences and how this may have impacted their IUD insertion experience; shadowing of patient's IUD insertions to observe the dynamics and interactions between patients and practitioners in real-time and from an outsider perspective; and the relationship between the patient's period cramps and their characterization of cramping during the insertion. The patients were all also college-educated and had some background knowledge on gynecology and the IUD insertion experience generally, so future research looking at patient perspectives should consider gaining a more educationally diverse sample size. Future research should also try to understand what methods of pain management patients would prefer, especially if the evidence is not conclusive on their effectiveness. Some related questions include: Would patients be interested in using pain management methods that are safe but not guaranteed to be effective? And while pain management options with little to no side effects or

discomfort during administration would be ideal, what type or extent of discomfort and/or side effects would patients be willing to tolerate to potentially prevent IUD insertion pain?

Practitioners should also ensure they stay up to date about the research on effective pain management methods for IUD insertions, and to consult and talk with patients on the available methods.

The ultimate goal for practitioners and for future research is to find a pain management method that is effective, has limited to no side effects, and does not cause excess pain. In the process, if there are pain management methods identified that have some combination of these 3 but perhaps not all of them, then they should be recommended as potential options. While this should remain the primary goal of future research, the thematic analysis highlights several areas that researchers should consider to ensure their studies are comprehensive and account for the many factors that can improve pain experiences during IUD insertions. Additionally, practitioners should use the practice recommendations identified in the thematic analysis to improve patient care and experiences of pain during IUD insertions.

Concluding Remarks

In conducting this research I set out to find answers to 4 main questions: what patients knew and how they felt about IUD insertion pain prior to the procedure; how they describe and characterize their experience of the insertion and post-insertion pain; how they felt about the handling of their IUD insertion pain and pain management; and what they believe would have made their experience better. There are no concrete, one-size-fits-all answers to these questions because each patient's preferences and each patient's body are different. Thematic analysis of patient perspectives thus offered a comprehensive approach to uncover the main unifying areas across all patients' IUD insertion experiences while also allowing for the inclusion of individual

patient differences. While patients felt the IUD insertion pain was legitimized in some ways, through consultations on, recognition of, and validation of their pain, they also felt their pain was not always adequately addressed.

This research is intended to inform prospective IUD patients, healthcare providers, and researchers by offering a better understanding of patients' experiences with IUD insertions, their expectations of practitioners, and their views on improving the overall experience. It provides valuable insights about pain that are important for individuals considering an IUD, serves as a resource for providers to better understand the needs and concerns of current patient populations, and helps researchers identify areas requiring further study, as well as the issues patients hope future research will address.

Part II. Perspectives and Players Within the Field of Gynecology

The most important perspective on pain in IUD insertions is the patient's perspective. However, perspectives within the field of gynecology can help to situate and understand patient experiences of IUD insertion pain and pain management within their broader context. Thus, in this chapter, I aim to explore medical practitioner perspectives and examine the various medical actors involved in the legitimization of IUD insertion pain.

OB/GYN Perspectives

I interviewed³ an OB/GYN and OB/GYN resident about their perspectives on pain in IUD insertions and the main barriers to addressing it. The OB/GYN, Dr. C, practices in a mixed community academic practice within a hospital system in Cleveland, Ohio. The first-year OB/GYN resident, Dr. T, practices in a major private hospital and academic center in Manhattan, New York. Throughout this chapter, I use their insight to frame discussions on medical training, how to reduce patients' pain as a practitioner, issues of pain in procedures involving the cervix, the use of anesthesia and sedation for IUD insertions, the CDC guidelines update, and shared-decision making and trauma-informed care. To summarize their understanding of and approach to pain during IUD insertions, I have highlighted key points and relevant quotes that emerged from our conversations.

Counseling Patients

Both physicians emphasized the importance and necessity of properly counseling patients about pain and pain management before the IUD insertion procedure. They both described that patients are often concerned about pain associated with the procedure, and recognized the importance of addressing any patient anxiety. Dr. T spoke to the substantial research showing

³ For a list of interview questions, see Appendix A (p. 75).

that patients' medical experiences are significantly improved and positively impacted when they are counseled on reasonable expectations for medical procedures. She described patient counseling as "one of the best tools clinicians have to impact somebody's experience," especially for giving patients reasonable expectations about what is considered normal for the procedure and what is not. Dr. T also emphasized the importance of counseling patients who are undergoing another procedure under general anesthesia to consider having their IUD placed at the same time, helping them avoid an additional visit and the pain associated with a separate IUD insertion.

In terms of counseling on pain management options, Dr. T and Dr. C explained that the existing research does not provide a great answer on which pain management would significantly reduce IUD insertion pain for patients, without putting them under general anesthesia⁴. Thus, the physicians tend to counsel patients that most of the existing pain management options are sub-optimal in some way or other, but their goal is to help patients identify a plan that will make them feel the most comfortable and incorporate the pain management they would prefer.

Variability in Patient Experiences

According to the physicians, the biggest barrier to addressing IUD insertion pain is variability in patients' bodies and their experience of pain. They both characterized the pain during IUD insertion as highly variable and difficult to predict. While they acknowledged that it is generally easier to place an IUD in multiparous patients, who often experience less pain due to a cervix that is already slightly open, this is not always the case. Some of their nulliparous patients have little to no issue with insertion, while some multiparous patients still experience significant pain. Most patients fall somewhere between these extremes, and individual experiences can vary widely—even among patients with similar anatomy and medical histories.

⁴ Refer to the "Anesthesia and Sedation" section on page 52 for a more in-depth discussion on the use of general anesthesia for IUD insertions.

Patients also often enter the procedure with preconceived expectations about how painful it will be, which can further contribute to the variability in their experiences, as pain is highly subjective and can be influenced by their expectations. Due to this variability and unpredictability and the sub-optimal options for pain management, physicians find that it is difficult to recommend a universal approach to managing pain for IUD insertions.

Responding to Patient's Pain

As Dr. T described, gynecological procedures like IUD insertions involve a particularly sensitive area of the body and put patients in vulnerable positions. Because of this, it is essential that providers stay highly attuned to what their patients are feeling and experiencing. Both physicians emphasized that it is not the provider's role to gauge the patient's pain but to listen carefully to and believe the patient's self-reporting of pain. They described routinely checking in during procedures by asking questions like, "How are you feeling?" or "Do you want to take a break?" to maintain open communication and set clear expectations throughout.

If a patient reports excessive pain during a procedure, the physicians immediately assess whether a more serious complication, such as uterine perforation, might be occurring. Regardless of the underlying cause, both physicians emphasized that if a patient says the pain is too much and asks to stop, their decision is respected without hesitation. In their practices, they prioritize taking cues directly from the patient: if a patient wants to pause or stop the procedure altogether, they listen and respond accordingly. Continuing against a patient's wishes would be unacceptable. They are committed to upholding patient autonomy, ensuring patients know they can take a break, stop completely, or explore other options at any time. Dr. C also noted that when patients know they have the option to stop, they often feel more in control and are better able to tolerate pain and discomfort.

Perspectives on Pain Management Options

As mentioned before, physicians are not satisfied with the existing evidence on pain management options for IUD insertions, and have difficulty recommending one method over another. They often advise patients to take ibuprofen or acetaminophen before the appointment, but recognize that it is more helpful for cramping post-insertion, rather than during the actual insertion. While they understand there is some evidence that paracervical blocks can be effective in reducing IUD insertion pain, Dr. C also explained that paracervical blocks anesthetize the uterus, and do not really anesthetize the cervix. Since many patients complain that the peak levels of pain are due to cervical manipulation, paracervical blocks may not be effective for this type of pain. He explained that it can be difficult to adequately anesthetize the cervix in a consistent way. Furthermore, he explained that paracervical blocks can also be painful (an injection into the vagina and cervix) while not necessarily providing a lot of benefit to the patient's experience. Similarly for misoprostol, he explained that it can help with cervical dilation, which may not be necessary for multiparous patients and may not be effective for nulliparous patients. Moreover, it is also likely to cause cramping, nausea, and diarrhea. However, both physicians emphasized that if patients request any of the available pain management options, they will ensure the patient's needs and choices are respected and supported.

Influence of Personal Experience on Practice

Dr. T's personal experience getting an IUD has meaningfully influenced her approach to patient care. Having personally navigated the procedure, she is able to counsel patients with an added layer of empathy and firsthand understanding. Dr. T observed that, in her own experience, pre-procedural anxiety was more significant than the procedural discomfort itself. As a result,

she prioritizes thorough pre-procedural counseling, with a focus on establishing realistic expectations and reinforcing patient autonomy in decision-making about IUD insertions. While she is open to sharing her personal experience with patients when it feels helpful, Dr. T is careful to contextualize it as a singular perspective, recognizing the variability in individual patient experiences. Overall, her firsthand experience has reinforced the value of counseling and empowering patients to feel informed and in control before the procedure begins.

Medical Training

As reflected in Dr. T's training and Dr. C's teaching, practitioners learn to perform IUD insertions with a strong emphasis on patient counseling and communication. While practitioners are taught that the procedure can cause discomfort, much of their training focuses on preparing patients through in-depth counseling about the available options for pain management. Residents are primarily educated on how to discuss pain control strategies with patients, rather than on recommending the use of specific interventions, as there is no universally accepted standard of care for pain management during IUD placement. Although public awareness and concern about procedural pain have increased in recent years, clinical practice has not significantly changed, largely because the literature has not established a clear or consistently effective method for managing pain during insertion. As part of their training, physicians are thus taught to personalize care, focusing on identifying the best solution and clinical setting to minimize discomfort and optimize feasibility for each patient.

Though the overall trend of medical training is towards these approaches, there is variability across the country in what practitioners are taught (and in what current practitioners were taught) and how they approach pain in IUD insertions. Unfortunately not all practitioners use shared decision-making or person-centered care. Some current practitioners were taught that

an IUD insertion feels like a little pinch and/or cramp (which is not an accurate description for all patients) and thus talk about the procedure in this way. Furthermore, these practitioners might not have any motivation or interest to change their methods or perspectives on IUD insertion pain. There is also a popular myth that the cervix does not have nerve endings and therefore does not experience pain. Although this myth has been disproven, some practitioners may still believe it, and it has not been completely eradicated from gynecological training and the field at large.

Procedural Changes and Techniques to Prevent Pain

Although IUD insertions can be painful for some patients, practitioners use a variety of strategies to minimize discomfort during the procedure. Dr. C's opinion is that, "the best thing that we can do is to A) do it quickly and get it over with, and B) to make sure it's done by somebody that you trust." He always reassures patients that if they do not feel comfortable with him, that's okay—he is happy to refer them to someone else or help them find a provider they feel more at ease with. Dr. C also believes building trust begins with these honest conversations. This open dialogue not only empowers patients but also establishes the foundation for a more positive experience.

Dr. C also adopts a minimalistic approach to the procedure, aiming to reduce unnecessary interventions that can cause additional pain. For example, Dr. C tries to avoid using the tenaculum—a surgical instrument used to stabilize the cervix—which can be particularly painful when placed. Though he describes that the tenaculum can be useful for practitioners, it is not always necessary. Whenever possible, Dr. C tries to insert the IUD without the tenaculum to reduce the patient's pain. Likewise, the sounding of the uterus (measuring its depth) can be done by using the IUD inserter itself, thus skipping an additional painful step. Research also shows that this direct or "torpedo" method reduced the pain patients experienced (Aissat et al.). Not all

practitioners use this method though, as the conventional method of IUD insertion is more widely taught. However, these procedural choices should be incorporated as much as possible as they not only reduce discomfort but also shorten the overall duration of the procedure.

While additional pain control methods like paracervical blocks are available, the physicians noted that they have limited effectiveness and can add complexity and discomfort. Injecting a local anesthetic at the tenaculum site requires piercing the cervix with a needle, which itself can be painful and extend the time the patient must spend in the office with a speculum in place. Therefore, Dr. C is among the practitioners who prefer to start with the least invasive approach and add more interventions only if necessary, tailoring the procedural plan based on the patient's body, responses, and preferences.

Dr. T frequently informs patients that if they are already scheduled for another procedure under general anesthesia, they can have an IUD placed at the same time. This strategy is also helpful for patients with a history of trauma, extreme anxiety, or anatomical challenges that might make office insertion difficult. Combining procedures not only reduces the number of invasive experiences for the patient but also helps ensure better pain management without additional burden.

Attention to small details also plays a role in improving patient comfort. For instance, although the standard practice for speculum insertion often involves using warm water, the use of lubricant on the external surface of the speculum has been shown to reduce discomfort without impacting procedural efficacy (Harmanli and Jones). Speculum insertion is frequently cited as a source of pain, and simple interventions like lubrication can make a meaningful difference in the patient's experience.

Overall, while the medical literature has yet to establish a single best method for pain management during an IUD insertion, practitioners continuously (and should continue to) adapt their techniques based on clinical experience and patient feedback. A person-centered approach—one that minimizes painful steps, incorporates patient preferences, and emphasizes trust and communication—remains key to efforts to reduce pain during IUD placement.

Issues of the Cervix

The Kinsey Reports were 2 ground-breaking and popular scientific books on sexual behavior that changed public perceptions of sexuality. However, this research also influenced public and medical perceptions on sensation and innervation in the cervix. As described in the research publication on female sexual behavior from 1953, only 5% of 878 women responded to gentle stroking of the cervix using a probe. This statistic was used to make the claim that “All of the clinical and experimental data show that the surface of the cervix is the most completely insensitive part of the female genital anatomy.” However, in the same report there was another statistic that said “84% of the same 878 women responded when the cervix was stimulated with ‘distinct pressure’ using ‘an object larger than a probe’” (Goldstein and Komisaruk). While this second statistic is more physiologically and procedurally relevant, the myth of insensitivity and the supposed absence of sensory nerve endings in the cervix perpetuated a medical disregard for cervical pain.

This widely believed myth about the cervix greatly influenced both the public and the medical field. As practitioners saw the cervix as a site of limited to no sensation, there was little regard for pain management in that region of the body. This had a direct and systemic impact on gynecological practice and how practitioners approached issues or procedures involving the

cervix. This impact is still seen today with the lack of effective pain management options for IUD insertions.

The issue of cervical pain management is not just limited to IUD insertions, but is also relevant for a variety of other gynecological procedures. Dr. T specifically described that endometrial biopsies, colposcopies and leaps are other in-office procedures that have suboptimal pain management options. Therefore, improving pain management for IUD insertions will also pave the way to better pain management in other cervical procedures.

Anesthesia and Sedation

Currently, the most effective known method of pain management for IUD insertion is general anesthesia. However, there are several reasons why routine use of general anesthesia is not always feasible, standard, or even wanted by patients for this type of procedure. The use of general anesthesia is medically justified when a procedure is especially long, complex, invasive, or painful. Since the IUD insertion procedure is overall very low-risk, quick, and simple, the use of general anesthesia is not indicated unless patients had a previous difficult insertion, their medical history has contraindications to getting the procedure done conventionally (such as medical conditions or traumatic experiences), they are concurrently getting a procedure under general, or they simply want to do the procedure under general. Moreover, not all clinics have the capacity or funds to support the use of general anesthesia, as it requires additional staff, equipment, and time. General anesthesia for IUD insertions is not always covered by insurance, which also means that patients would likely have to pay out-of-pocket for this cost. There are also potential risks to general anesthesia, and it requires the patient to be driven home after, as they will likely have side effects such as confusion, memory issues, and grogginess. General anesthesia additionally requires patients to fast before the procedure to prevent aspiration. While

in-office IUD insertions can happen on the same day as the consultation and do not require another visit, general anesthesia has to be scheduled at a later date based on OR and staff availability. Thus, the routine use of general anesthesia would make the procedure much longer, complicated, and expensive for patients, practitioners, and clinics.

Conscious IV sedation—where patients can remain awake and responsive during the procedure (avoiding some of the risks of general anesthesia)—is another potential pain management option for patients, but the evidence is not yet clear as to whether it actually helps reduce the experience of pain during IUD insertions. Although research has not consistently shown that conscious IV sedation reduces IUD insertion pain, some patients report higher satisfaction for their IUD insertion with the use of this pain management (though not necessarily a lower incidence of pain). More clinics have begun to offer it as an option, giving patients greater choice over how their pain is managed during the procedure and reducing their potential pre-procedural anxiety (Kayata). However, while the side effects of conscious IV sedation—such as confusion and grogginess—tend to wear off quicker than those of general anesthesia, it still requires additional staff, specialized equipment, and extra time, just like general anesthesia. According to an article in the *AMA Journal of Ethics*, requiring providers to offer costly and currently unproven pain management options could add another obstacle to IUD access, especially in settings with limited resources (Hutchison and Epsey).

In the current situation—where there is no clearly effective pain management option for IUD insertion aside from general anesthesia—the issue is one of cost, but also one of ethics. Is it more ethical to offer anesthesia and sedation to all patients to ensure no one endures unnecessary pain, even if some might not have experienced significant pain without it? Or is it more ethical to have it as a potential pain management option, but not a routinely, universally available one,

knowing that some patients will suffer as a result? Offering no anesthesia assumes some can tolerate the procedure, but risks neglecting those who cannot. Offering it routinely could pose significant financial and logistical challenges. It seems that what's needed is a balanced approach: improved evaluation of existing pain management methods, development of better options, and ethical frameworks that prioritize patient autonomy and pain prevention.

Practitioners should work with patients to identify their preferred pain management option and provide counseling on all available methods. If a patient's preferred method—such as conscious IV sedation or general anesthesia—is not available at their clinic, the practitioner should direct them to a clinic that does offer it.

CDC Guidelines Update

After 8 years of no updates to their 2016 practice guidelines on IUD insertions, the CDC finally updated their guidelines in 2024 to incorporate more information on pain management and provide current practice recommendations. Largely driven by media coverage and public advocacy highlighting patients' experiences with pain, the change marked a significant step toward federal legitimization of IUD insertion pain. Notably, one of the key updates was an increased emphasis on patient-centered care, including the necessity of counseling on pain management, shared decision-making, and trauma-informed care. Among other updates was not recommending misoprostol for routine use (only recommended for failed attempts or other similar situations) and indicating that lidocaine (through a paracervical block or topical application) could help reduce pain (Curtis et al.)

Though important, the CDC guidelines update did not solve the question of what the most effective pain management is for IUD insertions. While lauded by the media as a major update to practice, Dr. C felt differently:

“Whenever I read the popular articles on IUD placement, it just drives me crazy, because they clearly do not know what they're talking about...Because I remember when that CDC recommendation came out, they were like, the CDC is urging physicians...and I was like you guys don't understand the problem. It would be like urging cardiologists to consider heart transplants. It's like, what are you talking about? It was treated like a major update on the topic. So the CDC made that update, and it was very much a nothing update, like there wasn't really much substance to it, but the popular media treated it like a major update to practice and it was not.”

For many physicians, a major update to the IUD insertion procedure would be the identification of a very effective, safe, cost-efficient, and accessible pain management method. Moreover, for physicians who were already implementing similar practices in IUD insertions prior to the CDC guideline updates, the change had little to no impact on their approach. It remains unclear whether the updates influenced other providers who were not previously addressing pain management adequately. Since there is no regulatory body enforcing these guidelines, physician responses likely vary widely, with some adopting changes and others not responding at all. While the update recognizes the need for additional research on effective pain management and is representative of the increasing efforts to legitimize and address the pain in IUD insertions, it did not provide the main answers that physicians and patients are looking for.

AJOG Best Practice Recommendations

About three-quarters of the way through writing this senior thesis, the *American Journal of Obstetrics and Gynecology* (AJOG) published an article, “Best practices for reducing pain associated with intrauterine device placement,” outlining various methods to minimize discomfort and pain during IUD insertions. Much of the content draws from the same sources I

consulted for my research and is presented in a useful flowchart-style table (see Table 2) that summarizes key information from the article. The article and table also have much more in-depth and substantial information than the updated CDC guidelines. For example, rather than just mentioning terms like trauma-informed care and shared decision-making, the article explores what these look like in practice. As described in the article, to practice trauma-informed care, practitioners are encouraged to gather a patient history that explores factors potentially influencing IUD insertion pain—such as previous pain during pelvic exams or other gynecologic procedures, experiences of intimate partner or sexual violence, mental health conditions like anxiety or depression, and high levels of anticipated pain. In the section on shared decision-making, the article provides a table of risk factors that are associated with more pain during the procedure so that practitioners can use it as a starting point to have an open conversation with patients about their individual circumstances and needs (Bayer et al.). Overall, the article and table below are helpful tools for physicians and clinics to improve their approaches to IUD insertion pain management.

Table 2

Recommendations to Optimize IUD Placement Comfort

Procedure and aftercare recommendations			
Pre-procedure checklist: <ul style="list-style-type: none"> <input type="checkbox"/> Staff trained, equipment (see box on the right) and environment (below) prepared <input type="checkbox"/> All patient questions answered <input type="checkbox"/> Informed consent signed <input type="checkbox"/> No contraindications, including pregnancy <input type="checkbox"/> Patient ate and drank as appropriate <input type="checkbox"/> Patient has ride home or support person as appropriate 	Equipment checklist: <ul style="list-style-type: none"> <input type="checkbox"/> Procedure table and supplies checked by provider inserting IUD (duplicate supplies on hand) <input type="checkbox"/> Correct IUD in stock <input type="checkbox"/> Use draping for privacy <input type="checkbox"/> Ultrasound if challenging placement expected <input type="checkbox"/> Warm speculum and lubricant <input type="checkbox"/> Uterine sound (plastic sound or endometrial biopsy pipelle, max. 3 mm diameter) 		
Environmental, non-pharmacological, and CIM considerations*: patient preference & availability			
<ul style="list-style-type: none"> • Lighting: low light • Music: calming, slow, and rhythmic • Towels/packs: warm for abdomen; cold for forehead • Standing rotating fan: provides cooling and audio-tactile distraction • Aromatherapy: lavender or peppermint 	<ul style="list-style-type: none"> • Acupressure: teach Large Intestine-4 (LI4) or Spleen-6 (SP6) pre-procedure for use during and after the procedure (Figure 3) • Breathing techniques: teach square, 4:7:8, 3 part yogic, Sitali, or Sitkari for use during procedure • Reiki: many patients appreciate it, and there are no contraindications to use 		
Premedication: Naproxen: 1–2 hrs prior (Rx 500–550 mg, or 2 OTC = 440 mg) or Rx Ketorolac 20 mg 1–2 hrs prior or Ketorolac 30 mg IM 20 min prior or OTC Ibuprofen 800mg 1–2 hrs prior	Assess patient for risk factors for a potentially more painful procedure (see Table 1): Nulliparity, menstruation (nulligravidas), adolescence, not breastfeeding, no history of vaginal delivery, dysmenorrhea, prior failed insertion, LEEP, history of trauma, difficulty with pelvic exam, anxiety or mood disorder, anatomical variations		
Lower risk of IUD insertion pain	Higher risk of IUD insertion pain	Failed first placement	Significant anxiety
Patient informed choice and shared decision-making			
TOPICAL/LOCAL ANESTHETIC [ONSET]**: <ul style="list-style-type: none"> • 5 mL EMLA cream i.e. 2.5% lidocaine/2.5% prilocaine to cervix & canal (multipara) [5–7 mins] • 10% lidocaine spray to cervix & canal [3 mins] • 10 mL of 20 mg/mL mepivacaine through a hydrosonography catheter [2 mins]# 	ICB/PCB TECHNIQUE: <ul style="list-style-type: none"> • Buffer: 2 mL sodium bicarbonate • Tenaculum site: 2 mL 1%/2% lidocaine • ICB: 3.6 mL 2% lidocaine at 3, 6, 9, and 12 o'clock (see Figure 4A) • PCB: 18 mL 1% lidocaine: ~9ml each placed at 4 o'clock and 8 o'clock (see Figure 4B) 	MISOPROSTOL 400 mcg buccally or vaginally 3–4 hours prior to placement	ANXIOLYTICS [ONSET/PEAK]† <ul style="list-style-type: none"> • Midazolam 10 mg PO [10-20 mins/30–90 mins] • Lorazepam 1-2 mg SL [30 mins/60 mins] • Diazepam 5–10 mg [15-45 mins/1-2.5 hrs]
Placement techniques to reduce discomfort <ul style="list-style-type: none"> • If dilation is needed: consider topical local anesthetic or regional block; start with an os finder; use smallest possible dilator or sound • Appropriate size speculum (consider Pederson for nulliparous patients) • Single tooth tenaculum or Allis forceps (although no evidence of superiority) • Gently rock the tenaculum points onto the cervix, time the closure with the patient's exhalation; close the tenaculum one notch only • Verbally check in for discomfort. Offer to pause/stop • Use isometric contractions to reduce vasovagal event risk 		ULTRASOUND-GUIDED‡	Consider IV sedation or placement under anesthesia‡
		Therapeutic language: “verbocaine” (Figure 1) <ul style="list-style-type: none"> • Words: calm, slow, low tone; “discomfort,” “placement,” etc. • Control: “We can stop at any time. You are in control.” • Coping strategies: talk about other things; focus on support of bed underneath • “I am going to place the speculum.” • “Please soften your muscles.” 	
Post-procedure			
<ul style="list-style-type: none"> • Keep patient lying flat for 5 mins with legs out of stirrups • Gradually raise head of table in increments to prevent vasovagal reaction • Provide acupressure on Large Intestine-4 (LI4) or Spleen-6 (SP6) (Figure 3) 		<ul style="list-style-type: none"> • Review what to expect post-procedure, in office, and at home • Offer beverage/snack and heat pad/hot water bottle • Advise patient to take PO naproxen 440-550 mg every 12 hrs, or PO ibuprofen 600-800 mg every 6-8 hrs, with food, for first 24 hrs post-procedure 	

 Overarching principles: respect, empowerment, and choice
 Is discomfort tolerable? Ask permission at each step

Note. From American Journal of Obstetrics and Gynecology

Gynecological Interest in IUD Insertion Pain

For Dr. C, a more substantial indication of gynecology's interest in and efforts to legitimize IUD insertion pain can be found by looking at major OB/GYN journals and seeing the increasing amount of published research on pain management with IUD placements in the past few years. As I wrote my thesis, I found this to be true. Along with the AJOG article, I came across new articles addressing pain in IUD insertions almost every month.

Gynecologists are increasingly interested in addressing the pain associated with IUD insertion, both on an individual and institutional level. As Dr. C notes:

“The literature is actually very preoccupied with trying to figure out how to improve pain management for IUD placement. So if you want to get a room of OB/GYNs riled up, present data on pain management with IUD placement. It's a hot topic, because as much as we are often responsible for inflicting pain, we don't like doing it. So if there's a way to do it better, we want to know about it. But unfortunately, most of the ways of doing it better have not borne the kind of fruit that we're hoping for.”

While enthusiasm to identify more effective pain management exists within the field, progress is hampered by broader systemic issues, such as the chronic underfunding of women's health research and attacks by the current presidential administration to hinder women's health research. Yet, the growing body of research signals that IUD insertion pain is no longer being overlooked, and there is clear momentum toward finding more effective, person-centered solutions.

Part III. Bridging the Gaps: The Remaining Steps Towards Legitimization

There are notable alignments between patient and practitioner perspectives on IUD insertion pain, suggesting a promising shift among practitioners towards better understanding and validating patient experiences. Importantly, key differences remain between patient and practitioner perspectives.

Patients largely expressed confusion and frustration at the lack of effective pain management, often interpreting it as part of a broader disregard for women's pain. Though some practitioners are making modifications at the individual level, the field as a whole must more explicitly acknowledge the structural roots of this issue. Outdated medical tools, chronic underfunding of women's health research, gynecology's violent and exploitative history, and persistent misconceptions about female anatomy all contribute to a systemic failure to adequately address and validate IUD patients' pain.

Practitioners overall find that the variability in patients' experiences of pain and inconclusive research on pain management are the primary barriers to effective pain management. Their approach tends to be highly evidence-based, with interventions not routinely incorporated until proven effective in clinical studies. While this prioritization of efficacy is important, the pursuit of an "ideal" solution may be inadvertently impeding progress. In the absence of definitive evidence, practitioners may be hesitant to implement changes, allowing the continuation of potentially painful practices.

Among both practitioners and patients there is a general mindset that, currently, in order to get an IUD, pain is just something that patients have to deal with. Such rhetoric—that enduring pain is a necessary tradeoff for receiving necessary healthcare—must be actively challenged. There should instead be a shift toward counseling patients on all currently available

options—both pharmacological and non-pharmacological—while also committing to a model of care that centers patient autonomy, informed choice, and procedural transparency. Without this shift, practitioners mindsets may unintentionally shape patient expectations of pain in gynecologic procedures and hinder systemic change.

Not every medical procedure or phenomenon is equally painful: every individual's body is different. Yet, this reasoning is not a justification for letting some people bear this pain, while those fortunate enough to not experience the pain serve as the reference point or gold standard for discussions on pain management. In the fight for legitimization of IUD insertion pain, we are at the point where physicians are recognizing that patients can experience significant pain during insertion, and they are supportive of finding better pain management methods for patients. However, there is not enough effort in day-to-day practice to make changes in the pain management routinely offered or used, partly because of financial constraints, but also because practitioners are not convinced that the existing pain management methods are effective enough. Practitioners and gynecological providers still hold power over what pain management patients are actually informed about and which options they are willing and/or able to provide. Thus, IUD insertion pain is more commonly recognized, believed, and validated than it was historically, but it is still not adequately addressed. Even in this absence of effective pain management, having open conversations and truly listening and responding to patients' pain will make a world of difference for patients' IUD insertion experiences.

Conclusion

The intrauterine device (IUD) is an incredibly effective form of long-lasting, reversible, and low-maintenance contraception, making it a vital healthcare option for those seeking reliable birth control. Its existence and accessibility are crucial, and it should continue to be offered to patients who want it, even if current pain management methods are still suboptimal. However, this does not mean that the pain associated with IUD insertions should be accepted as inevitable. Practitioners, researchers, and medical institutions must continue to prioritize patient comfort and actively work to identify and implement the most effective strategies for managing pain.

While IUD insertion pain has been legitimized in a variety of ways, there is still a long way to go. Improving pain management in this area will not just benefit future IUD patients, but will also raise the standard of care for all gynecological procedures that involve cervical manipulation. Without better options, patients may be forced to endure the same pain again just to access basic and necessary healthcare.

The fight to acknowledge and address IUD insertion pain is part of a larger, ongoing struggle to have women's pain taken seriously within the medical sphere. The work of the legitimization of women's pain continues, and medical institutions, researchers, practitioners, and patients must work together to achieve it.

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Appendix A

Interview Questions

Patients

- When did you get your IUD inserted/removed?
- What type of IUD did you get?
- Where did you get your IUD (city, state, type of clinic/hospital (public/private, major, minor)?
- What type of medical practitioner did your IUD insertion?
- What were your reasons for choosing to get an IUD over other forms of contraception? Were you considering any other forms as well?
- What were your concerns before the insertion?
- What had you heard about pain during IUD insertions prior to getting one? Did this influence your decision at all?
- Did you feel anxious about your insertion at all?
- Was pain something you were thinking about or scared of prior to your IUD insertion?
 - Was there anything you did to address your fears?
 - What did your doctor talk to you about before/during/after wrt pain management?
 - Did you talk to your medical provider about your concerns wrt to pain? What did you/they say?
- What did you do / were given for pain management before / during / after?
- How was the experience/pain for you? Walk me through what you remember from the experience, from start to end. Include your feelings, thoughts, concerns throughout, and also how the medical provider responded to them.
- What is something you appreciated/did not appreciate about how a doctor has handled your pain/pain relief?
 - Is there anything you specifically remember them saying that was either helpful or harmful?
- Is there anything you wish they did differently / incorporated / asked?
- Do you feel any of your complaints of pain were heard / valued during the insertion process?
 - If the insertion was painful, did you tell your provider about it / did you feel that your pain was listened to?
- Had you been to the gynecologist before this / did you have comfortable appointments? Did you have any non-ideal experiences at the gynecologist?
 - What have your previous experiences been with gynecologists?
 - Was it a new gynecologist doing your procedure or were you familiar with them?

- Had you had penetrative sex before the insertion? Do you think this impacted your experience of getting an IUD?
- Have you sought other means of pain relief beyond the medical establishment?
- Have you found your own methods of getting pain relief beyond your doctor?
- How was the experience of IUD removal compared to insertion? Is there anything you did differently / thought about differently / prepared differently?
- Would you never get it put in again?
 - What about if the pain was addressed?
- Do you feel like your pain was legitimized / addressed during your IUD insertion?
- Is there anything else you want to share / you think would be important for me to know?

Practitioners

- In what type of healthcare facility do you currently practice? (type of hospital/clinic, private/public, major/minor)
- Where/when were you trained on how to perform IUD insertions?
 - How long ago was it? What were you taught about with respect to pain in IUD insertions?
 - What were you taught to do about pain during the procedure? Were any pain management techniques recommended / taught to you?
 - What language was used to describe the pain in the procedure?
 - Do you still use this language?
 - Has anything significantly changed since you learned it, such as anything changed in how it is taught, talked about, or performed, especially in relation to pain?
- Do you currently place IUD's? How many / how often?
- How would characterize the IUD insertion procedure with respect to pain?
 - What are the parts of the procedure that are most painful/how long does the pain last? (cramping / pain after insertion)?
 - Is there a reported difference in pain between the different IUDs? Or have you noticed one?
- Do you find that pain is something patients are concerned about with regards to the procedure?
 - How do you address patient concerns about pain?
- Do you discuss pain management / pain in the insertion with all patients prior to the insertion?
 - How do you advise patients on pain management?
 - Do you give patients some form of pain relief? What do you use (both pharmacological and non-)?

- Is there anything you have seen be effective / ineffective with regards to pain management?
- Do the patients you see overall complain about pain during the procedure?
 - Are there any particular patient populations (based on parity, age, medical history, menstruating or non, etc) that you have noticed particularly complaining of pain during the procedure?
 - Have you noticed any differences between nulliparous vs parous patients?
 - Have you noticed any differences in experiences of pain when patients are menstruating?
- What makes you stop a procedure / decide the patient is in too much pain?
 - Is there something they say / do?
 - If a patient is silent, what does that mean to you regarding their pain?
 - Because the procedure is relatively quick, is there a rhetoric of powering through the pain to get the IUD in?
- Are you familiar with the latest CDC update to the IUD insertion guidelines after 8 years?
 - Has anything changed in your approaches since the CDC recommendation?
- What do you think are the biggest barriers to addressing pain in IUD insertions?
- Is there anything else you want to share / you think would be important for me to know?

Appendix B

Supplemental Table 1.

Example of codes created from interview transcript quotes

Themes & Subthemes	Codes	Interview Transcripts
Theme 1: Anxiety and concern about pain before the IUD insertion	Patient felt anxious about her IUD insertion because she was not sure exactly what would happen and what to expect	I think so [I was anxious]. I think I was nervous about the pain and I didn't really know what to expect. I don't know, I didn't know how bad it would be, so I was like oh, okay, whatever. Like it'll probably be fine, you know.
Subtheme 1: Hearing stories about other patients' IUD insertions	Patient felt scared about her IUD insertion because she had heard friends stories about them being in pain, and the less painful stories seemed more rare	I feel like, just hearing stories about people's IUD insertion experience and everything, I was like, nah. Like, I was like, I needed, I needed some time to mentally prepare for that, just because, you know, everyone's had so many different stories and experiences, and I feel like the most negative ones are the ones that stick out for me.
	Patient had heard previous negative stories about pain in IUD insertions	
Subtheme 2: Appreciation for anxiety-reducing methods and interventions	Patient felt that the non-pharmaceutical methods were helpful with managing overall anxiety and improving the overall experience whether or not they would not physically reduce the experience of pain	And pain management, they gave me like a heat pad, which they didn't do in the other one, and that was really nice cause it just gave me something else to think about, and they played music, that really helped, um yeah, so, it was good. And like they put aromatherapy, and it wasn't even about, like what the aromatherapy was doing, it was just the fact that, like, they were doing it for me, you know what I mean? I'm like, okay, like this is nice, yeah.

	Patient thought methods to make environment more comfortable were nice but felt they would not make much difference with the pain at the point of insertion	That was nice, so I kind of had an environment that I felt I don't know, a little bit more comfortable in, although I think at the point of insertion you're not really thinking about, you know, like this sound or ambiance.
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Supplemental Table 2.

Example of codes used to identify each theme and subtheme

Themes & Subthemes	Codes
Theme 1: Anxiety and concern about pain before the IUD insertion	Patient felt anxious about her IUD insertion because she was not sure exactly what would happen and what to expect
	Patient did not process how painful it would be did not feel anxious about IUD insertion until right before insertion
	Patient was not anxious or overly concerned before her IUD insertion
Subtheme 1: Hearing stories about other patients' IUD insertions	Patient felt scared about her IUD insertion because she had heard friends stories about them being in pain, and the less painful stories seemed more rare
	Patient did not much know about pain during the procedure before getting it
	Patient had heard previous negative stories about pain in IUD insertions
Subtheme 2: Appreciation for anxiety-reducing methods and interventions	Patient felt that the non-pharmacological methods were helpful with managing overall anxiety and improving the overall experience whether or not they would not physically reduce the experience of pain
	Patient thought methods to make environment more comfortable were nice but felt they would not make much difference with the pain at the point of insertion
Theme 2: The necessity of being informed	Patient liked that there nothing was unexpected during the procedure as she was well informed

	Patient felt the steps of her IUD insertion were not adequately or clearly explained to her before her insertion
Subtheme 1: Consultations on pain management options	Patient was not consulted on potential pain management options
	Patient did receive a general consultation on what the procedure would involve, but not much discussion on the pain
	Patient was told to take OTC pain meds before appointment to prevent feeling cramps too much
	Patient was told by the gynecologist to use specific pain management otherwise the pain would be too much
	Patient does not understand why IUD insertion pain has not been better addressed yet
Subtheme 2: Knowing what is being done to one's body throughout the procedure	Patients appreciated knowing beforehand exactly what the insertion procedure would entail, including steps and length of time for each one
	Patient appreciated knowing/being told that there were a limited amount of times she would feel the cramping pain during the insertion
	Patient did not appreciate how the doctors were having trouble with the procedure and were not clearly explaining how long the procedure would take and/or if they could figure it out
Subtheme 3: Clearer, more objective language about the IUD insertion steps	Patient felt having more of a step by step of what was happening would have made the experience more comfortable, especially because the insertion is done in an awkward, uncomfortable setting/position
	Patient felt the pain was described using very blanket terms
Theme 3: There is no other option but to push through the pain	Patient felt that she just had to get through the uncomfortable pain, nothing else that could be done in that moment
	Patient felt there was nothing else that could be done about the pain/discomfort during insertion, and that she just had to power through it because that is just how it is

	Patient feels there was not much else that could have helped her situation but some form of effective pain relief
Theme 4: Regretting the IUD during experiences of intense pain	Patient regretted decision to get IUD during peak moment of pain but then feels overall satisfied with decision to get an IUD in the days/weeks/months after
	Patient said that if she could change anything about her care, she wouldn't have gotten the IUD
	Patient would never get the copper IUD again because of insertion pain and bodily reaction to it
Theme 5: Recognition of differences between individual patient experiences	Patient recognizes that not all iud insertion experiences are the same, and not all are tolerable like hers
	Patient felt that her negative experience with the IUD was because her body just reacted strongly against it
	Patient knows many people with similarly painful IUD insertion experiences
Subtheme 1: Estimations and expectations of pain	Patient feels provider underestimated pain to not scare her/patients in general
	Patient described pain as being more intense than expected
	Patient had a much worse experience than she thought she would have
	Patient appreciated that the experience was not as bad as she expected it would be
Subtheme 2: The peak-end rule for pain in IUD insertions	Patient feels she had a good IUD insertion experience due to her pain management, the prestige of the medical clinic she visited the personal connection she had to her obgyn, and familial help during the recovery process
	Patient had significant pain during insertion but now feels satisfied with IUD
Theme 6: The role of the practitioner	Patient felt that the provider did a good job of making her feel comfortable
	Patient does not feel the provider did anything wrong, feels that it is just the way it is
	Patient feels she had a good iud insertion experience due to the personal connection she had to her obgyn

	Patient trusts gynecologist and appreciates that she gives her agency
	Patient appreciated that the gynecologist verbally responded and validated her pain
	Patient felt the gynecologist did a good job because she had no complications post-insertion