## EXAMINATION ACCOMMODATIONS BY CNMs AND WHNPs FOR FEMALE SEXUAL ASSAULT SURVIVORS

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## **ABSTRACT**

Background: The CDC reported 1 in 5 women (19.3%) will experience sexual assault or rape during their lifetime. Thus, as advanced practice nurses (APNs) who work primarily with women, there is a ~20% chance that certified nurse midwives (CNMs) and women's health nurse practitioners (WHNPs) will provide care to a sexual assault survivor.<sup>2,3</sup> Little data exist regarding how APNs provide care to survivors during breast/pelvic exams.<sup>4,5</sup> Aims: (1) describe how CNMs and WHNPs screen for history of sexual assault; (2) describe how CNMs and WHNPs accommodate needs of adult female sexual assault survivors; (3) identify how CNMs and WHNPs comply with requests made by survivors; (4) compare CNMs' and WHNPs' accommodation and compliance practices. Methods: Descriptive study using survey design. Online investigator-created, 65-item survey was used. The principal investigator (PI) asked directors of WHNP and CNM programs in the US to disseminate an invitation inviting faculty to participate in this study. Statistical analysis included means (SD) for continuous variables, frequencies (%) for categorical variables, and Mann-Whitney U tests for non-parametric data. Results: Total sample was 18 APNs; CNMs (n=10) and WHNPs (n=8). Survey response rate ~32%. CNMs were more likely to accommodate their breast/pelvic exam practices for all known/suspected survivors (survivors), and were significantly more likely to comply with requests by survivors when preparing for a breast/pelvic exam (p=0.02). APNs who were the same race as the majority of their patient population were less likely to screen for history of sexual assault (p=0.10). Conclusion: A low percentage of CNMs and WHNPs reported always screening for sexual assault. In general, CNMs were more likely than WHNPs to accommodate the needs of survivors during both preparation for and conduct of breast/pelvic exams.

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## MATERIALS AND METHODS

Study design: Descriptive, cross-sectional design. Inclusion criteria: (1) certified, practicing CNM or WHNP in the US; (2) teaching in class, clinical, or online settings in full time, part time, or adjunct positions; (3) Internet access for survey completion; (4) proficient in reading/writing English. Sampling plan: Convenience sample recruited from accredited academic nursing institutions. Research instrument: Investigator-created, 65-question, self-completed survey with five parts: (1) Participant Demographics; (2) Patient Demographics; (3) Meeting and Screening Patient; (4) Preparing for Exam; (5) Conducting Exam. Questions for survey sections 3, 4, and 5 were measured using Likert Scale: 1=always; 2=frequently; 3=seldom; 4=never. Procedures: PI sent invitational email to CNM and WHNP program directors (PDs) to disseminate to eligible faculty. PDs were listed on Association of Certified Nurse Midwives and National Association of Nurse Practitioners in Women's Health websites. The email included study rationale, informed consent, and survey link. PDs were asked to inform PI of distribution list total faculty number. Identical email was sent one week later to PDs who had not responded. Informed consent was implied through survey completion. Data collection was from 02/17/2016 to 03/02/2016. Statistical analysis: Descriptive statistics were calculated for all demographical information. A *p* value <0.05 indicated a statistically significant relationship and a *p* value ≤0.10 indicated a relationship trending towards statistical significance.

## RESULTS

- Survey Response Rate: ~32% of eligible participants
- Sample Demographics: Eighteen female participants, mean age 48.5 years, 94% White, 6% multiracial, 89% non-Hispanic or Latino. Sample included 10 CNMs and 8 WHNPs with sample mean of 19.6 years practice experience. 72.2% were the same race as their patient population; 27.8% were a different race. Highest nursing degrees included masters degree (50%), doctorate of nursing practice (DNP) (33%), and PhD (17%) (Figure 1).

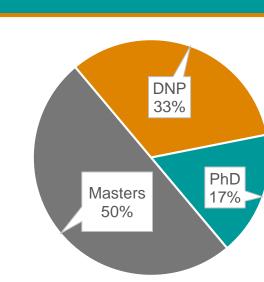


Figure 1. Highest Nursing Degree

## RESULTS

## Aim 1: Describe how CNMs and WHNPs screen for a history of sexual assault

- 22% reported always screening for a history of sexual assault
- Most common reasons for not screening varied (Figure 2)
- Trend towards significance seen with relationship between provider of same race as majority of patient population + likelihood to screen for a history of sexual assault (*p*=0.10)

## Aim 2: Describe ways in which CNMs and WHNPs modify their practice to accommodate the needs of all survivors

- Preparing for exam: WHNP mean score 1.14; CNM mean score 1.08
- Conducting exam: WHNP mean score 2.11; CNM mean score 1.74 (Figure 3)

# Aim 3: Identify CNM and WHNP level of compliance with requests made by survivors during preparation for and conduction of exams

- Preparing for exam: WHNP mean score 1.11; CNM mean score 1.00
- Conducting exam: WHNP mean score 1.47; CNM mean score 1.29 (Figure 3)
- Masters-prepared CNMs and WHNPs had lower mean scores than both PhD-prepared and DNP-prepared nurses regarding complying with survivor requests during preparation for breast/pelvic exams. DNP-prepared nurses were the least likely to comply with patient requests during preparation for exam.

## Aim 4: Compare the accommodation and compliance practices of CNMs and WHNPs

- CNMs were significantly more likely to comply with survivor requests than WHNPs when preparing for breast/pelvic exams (*p*=0.02, power=0.83) (Figure 3)
- CNMs were more likely than WHNPs to accommodate their practice for all survivors when conducting breast/pelvic exams (p=0.10)

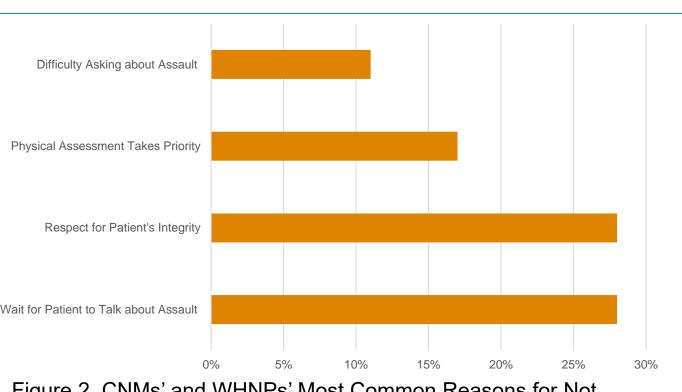
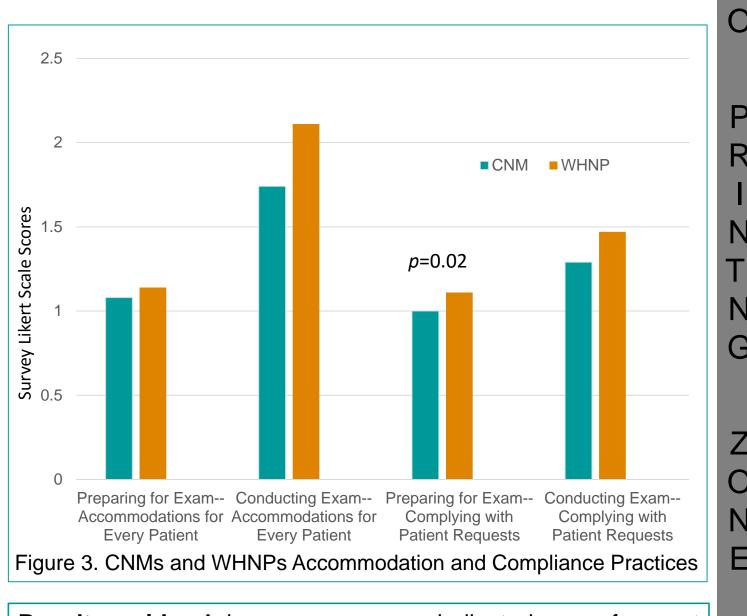


Figure 2. CNMs' and WHNPs' Most Common Reasons for Not Screening for History of Sexual Assault



**Results guide:** A lower mean score indicated more frequent accommodation and compliance practices for survivors by CNMs and WHNPs.

Likert scale: 1=always, 2=frequently, 3=seldom, 4=never

#### Limitations

- Low survey response rate
- Reliance on PD gatekeeper to disseminate survey
- Social desirability regarding survey responses

## CONCLUSIONS

A low percentage of CNMs and WHNPs reported always screening for a history of sexual assault. There were diverse common reasons reported for not screening. In general, CNMs were more likely to accommodate the needs of survivors during both preparation for and conduct of breast/pelvic exams. WHNPs were significantly less likely to comply with survivor requests while preparing for breast/pelvic exams. Few results were significant.

Acknowledgements: Investigators thank the CNMs and WHNPs who chose to participate in this study. Funding for this study was provided by the Georgetown University Tau Chapter, Sigma Theta Tau International. <sup>1</sup>Breiding, M., Smith, S., Basile, K., Walters, M., Chen, J., & Merrick, M. (2014). Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization — National Intimate Partner and Sexual Violence Survey, United States, 2011. Center for Disease Control and Prevention, Division of Violence Prevention. Atlanta: Center for Disease Control and Prevention. <sup>2</sup>Cadman, L., Waller, J., Ashdown-Barr, L., & Szarewski, A. (2010). Barriers to cervical screening in women who have experienced sexual abuse: an exploratory study. *Journal Family Planning and Reproductive Health Care*, 38(1), 214-220. <sup>3</sup>Leeners, B., Stiller, R., Block, E., Gorres, G., Imthurn, B., & Rath, W. (2007). Effect of childhood sexual abuse on gynecologic care as an adult. *Psychosomatics*, 48(5), 385-393. <sup>4</sup>Montgomery, E. (2013). Feeling Safe: A metasynthesis of the maternity care needs of women who were sexually abused in childhood. *Birth: Issues in Perinatal Care*, 40(2), 88-95. <sup>5</sup>Montgomery, E., Pope, C. & Rogers, L. (2015). A feminist parrative of the maternity care experiences of women who were sexually abused in childhood. *Birth: Issues in Perinatal Care*, 40(2), 88-95. <sup>5</sup>Montgomery, E., Pope, C. & Rogers, L. (2015). A feminist parrative of the maternity care experiences of women who were sexually abused in childhood. *Birth: Issues in Perinatal Care*, 40(2), 88-95. <sup>5</sup>Montgomery, E., Pope, C. & Rogers, L. (2015). A feminist parrative of the maternity care experiences of women who were sexually abused in childhood. *Birth: Issues in Perinatal Care*, 40(2), 88-95. <sup>5</sup>Montgomery, E., Pope, C. & Rogers, L. (2015). A feminist parrative of the maternity care experiences of women who were sexually abused in childhood.