Sexual Abuse of Vulnerable Adults: The Medical Director’s Response

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Sexual abuse is the least recognized and reported form of mistreatment of vulnerable adults (adults that are elderly or disabled), representing less than 1% of mistreatment reported in the United States. However, sexual victimization is underreported in all age groups and has been shown to be significantly underreported in the elder and disabled populations. This may be a result of generational beliefs about sexuality and morality, embarrassment, shame, and guilt. Sexual abuse of vulnerable adults may occur in the community as well as any long-term care setting. The purpose of this article is to present information for medical directors of long-term care facilities.

The elderly sexual abuse victim is typically female (although males can be victims), cognitively impaired, and frail. The abusers are commonly male (although females can be abusers) and may be caregivers, relatives, or residents in a long-term care facility. Elders living in a long-term care setting may be at increased risk for this type of abuse because of frailty and dependence on others for their care. For persons with a disability, the rate of sexual abuse is higher than the general population and highest for those with developmental disability and intellectual impairment.

The National Center on Elder Abuse defines sexual abuse as “nonconsensual sexual contact of any kind.” This can include unwanted sexual advances, fondling, forced viewing of pornography, sexualized kissing, oral-genital contact, digital penetration, and rape. An alternate definition is when an elder is “forced, tricked, coerced or manipulated into unwanted sexual contact . . . also includes sexual contact with elders who are unable to grant informed consent.” In long-term care facilities, there are 2 subtypes of sexual abuse. First is coercion of a subject with capacity to consent, and second the exploitation of a subject without capacity to consent. The most commonly reported forms of sexual abuse in one study were sexualized kissing and fondling, but ranged from unwanted sexual advances and rape.

The medical director must be aware of the risk of sexual abuse of elderly or disabled adults in any setting. As the leader of a multidisciplinary team, the director must work with staff to increase awareness, detection, and prevention of this problem. The medical director should be knowledgeable about all types of abuse of vulnerable adults, and about sexual abuse in particular. This includes having an awareness of the physical and emotional manifestations of sexual abuse as well as techniques to preserve evidence once sexual abuse is suspected.

CASE STUDY: MS. A

Ms. A was a 69-year-old resident of a dementia unit in a nursing home who had severe dementia, hypertension, and macular degeneration. She had impairments in speech and communication and required assistance with all activities of daily living. She was able to ambulate a few steps with a walker. Ms. A’s daughter came to visit her every Saturday at the nursing home. On one particular Saturday, she noted that there were bruises on her mother’s face and that she was very agitated. When she asked the nurses about the bruises, she was told that her mother had fallen 2 days previously. However, later in the day, the daughter was helping to bathe her mother and noted bruises along the inner thighs bilaterally. She was very concerned and asked to speak to Ms. A’s physician. The primary physician was not available.

The nurse called the medical director who reviewed the medical record and examined the patient. There was no documentation in the medical chart of a fall and no incident report had been filed. On examination, the medical director found that the resident had severe speech impairment and was unable to give any history, but appeared very agitated. She had a large left periorbital ecchymosis and a large hematoma at the left jawline, both purplish-blue in color. She also had a 3-cm scalp hematoma on the right occipital area. Both inner thighs revealed multiple purplish-blue hematomas of varying sizes. The external genitalia did not reveal any obvious signs of trauma. Both the daughter and the nurse were suspecting possible sexual abuse and asked the medical director what they should do next.

What is the role of the medical director and his or her staff in this instance? Do they have any legal responsibilities? What resources and options are available to the medical director and his or her staff?

DISCUSSION

Recognizing Signs of Possible Sexual Abuse

When an older or disabled adult reports sexual abuse, it is important that the allegation is taken seriously and that the victim feels that he or she is heard. Many elders or disabled adults with cognitive impairment may be unable to report the abuse. Thus, it is imperative that all health care providers be
aware of possible physical and behavioral indicators of sexual abuse. As in this case, any bruising or injuries in the genital area or inner thighs should raise the suspicion of possible sexual abuse. In a recent study involving 125 cases of elder sexual abuse, half of the victims had vaginal trauma and one third had bruising to the labia. One half of the victims sustained injury (bruising or abrasion) to a nongenital part of their body.9 Anal injuries can occur in male or female victims of sexual assault and should be a routine part of the sexual abuse examination. Other physical signs that may alert a physician or other long-term care staff to possible sexual abuse include a sexually transmitted disease, bleeding or bloodstained underclothing, pain, or difficulty sitting. Table 1 lists some physical markers of possible sexual abuse.

Behavioral or emotional changes, as occurred with Ms. A, may occur as a result of a sexual assault. For adults and elders with cognitive impairment, these changes may be a possible indicator of sexual abuse. This may include fear of a particular individual, fear of bathing, or fear of being touched. The victim may display hypersexual, aggressive, or regressive behavior. The victim may show signs of withdrawal, anger, depression, or sleep problems.10 Although these are not specific indicators, they should prompt the medical provider to consider the possibility of sexual abuse. These indicators may be difficult to detect in patients with dementia or cognitive impairment, but dramatic changes from baseline behavior should be noted.11 Table 2 lists some behavioral indicators of possible sexual abuse.

### Reporting Suspected Sexual Abuse

When sexual abuse of an elder or disabled adult is suspected, the medical director and his or her staff have the responsibility to report that suspicion. Most states mandate the reporting of suspected sexual abuse to Adult Protective Services or the ombudsman.5 If there is “reasonable suspicion” that sexual abuse has occurred, a report should be made right away. Health care providers should have a low threshold for reporting a suspicion of sexual abuse. This type of abuse can have serious health and psychological consequences for the resident and can also impact the resident’s family, other residents, staff, and potentially the perpetrator and the community. Because sexual abuse is potentially a crime (depending on state definitions5), suspected sexual abuse should be reported to law enforcement.

There are several barriers to reporting suspected sexual abuse. One barrier is that the elder victim may suffer from cognitive impairment and may be unable to report. The caregiver may be concerned that the older victim is delusional and that the abuse did not really occur. Another possible barrier is that the older victim may not be believed. For example, the victim may be assumed to be cognitively impaired, even when the victim is not. In the case of Ms. A, the patient has cognitive impairment and difficulties with communication, both of which can be serious barriers to identifying elder sexual abuse.

### Sexual Abuse History

When evaluating a resident who may be a victim of sexual abuse, the history is very important and should be carefully documented by the health care provider. The interview of the sexual abuse victim should be conducted in a setting that ensures both the privacy and the safety of the victim. The victim should be given an opportunity to describe what happened. The victim’s statements should be documented and direct quotations used if possible. The interviewer should express concern and validate the victim’s feelings. At times, a victim may be unable to describe the incident of abuse because of physical, emotional, or psychiatric reasons. There may be other witnesses to the abuse within the facility (staff, visitors, or other residents) who are competent to make a statement. The interviewer also should briefly describe the patient’s demeanor, as changes in behavior may reveal symptoms of trauma.12 The patient’s cognitive status should be documented because this can be important as a possible risk factor for sexual abuse and as a marker of the patient’s ability to consent to sexual contact. Documentation of the resident’s underlying cognitive status would be important as well as a current evaluation with a Mini-Mental Status Examination (MMSE) by a provider trained in performing the MMSE. In determining capacity to consent to sexual contact, there are no clear-cut guidelines. One guideline that has been proposed involves an assessment of the resident’s MMSE, awareness of the relationship, ability to avoid exploitation, and awareness of potential risk.13 When cognitive impairment is present, the patient may not be able to give a history or even consent to a sexual abuse examination. In these cases, it may be the family and/or law enforcement that consent for the examination. The forensic evidence and documentation become even more essential in cases where the patient is unable to give a history.

| Table 1. Physical Indicators of Possible Sexual Abuse2,5,6,10 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| **Bruising on inner thighs, buttocks, breasts** | **Genital injuries: abrasions, lacerations, bleeding** | **Anal injuries: lacerations, bleeding** | **Oral injuries: bruising, petechiae** |
| **Bite marks** | **Sexually transmitted diseases** | **Pain or itching in the genital areas** | **Pain or difficulty walking, sitting, or urinating** |
| **Any non-genital physical injury** | **Pregnancy (disabled adult of child-bearing age)** | **Bleeding or bloodstained sheets or underclothing** |

| Table 2. Behavioral Indicators of Possible Sexual Abuse2,6,10 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| **Change in behavior or personality** | **Fear of certain individuals** | **Extreme upset when being bathed or changed** | **Odd or misplaced comments about sex or sexual behavior** |
| **Troubled sleep/nightmares** | **Regressive or aggressive behavior** | **Self-destructive behavior** | **Disturbed peer interactions** |
| **Depression** | | | | |
Sexual Abuse Examination

When sexual abuse of an elder or disabled adult is suspected, it is important that the examination and evidence collection be conducted by a professional trained in forensics. Many counties are fortunate to have a Sexual Assault Response Team (SART), a multidisciplinary team with medical, psychological, and forensic components. A SART team can perform the sexual abuse examination and collect evidence in a standardized fashion. This allows for critical information and evidence to be obtained and injuries to be medically treated. Additionally, many SART teams are associated with a rape advocacy group that provides emotional support to the victim throughout the examination process and thereafter. The forensic examination of the elderly or disabled sexual abuse victim may be difficult because of leg contractures, pain, or injury and possible cognitive impairment. In the case of abuse victim may be difficult because of leg contractures, pain, and evidence to be obtained and injuries to be medically treated. Additionally, many SART teams are associated with a rape advocacy group that provides emotional support to the victim throughout the examination process and thereafter.

The forensic examination of the elderly or disabled sexual abuse victim may be difficult because of leg contractures, pain, or injury and possible cognitive impairment. In the case of developmentally disabled adults, the examination may be particularly difficult because of a lack of understanding of the examination and poor communication skills. Some examiners have suggested the use of dolls or anatomic drawings that are commonly used in the evaluation of child victims.

Findings on the sexual abuse examination may range in severity from swelling and tenderness to severe lacerations and fractures. Postmenopausal women who have been sexually assaulted are more likely to sustain genital trauma than younger victims. In 28% of older women who are sexually assaulted, injuries sustained to the genital area may be severe enough to warrant surgical repair. As women age, there are physiologic changes in the genital tract that may result in vaginal dryness and thinning of the vaginal mucosa. Additionally, in both men and women, muscle atrophy, osteoporosis, and decreased subcutaneous tissue can be contributing factors to the severity of injury. For adults with disability, contractures, muscle rigidity, and medications may lead to more severe injuries as a result of sexual assault.

A recent study compared nursing home sexual abuse cases versus non-nursing home cases and found that nursing home victims were less likely to have a rape kit used for evidence collection and potential evidence was destroyed in the facility (sheets were washed or the patient bathed before evidence could be collected). When dealing with a suspected sexual abuse case, it is important to realize that time and certain activities can potentially destroy evidence. The victim should be examined by a SART team as soon as possible and should not shower, brush teeth, or change clothes before the examination. The medical director, when performing a physical examination on a patient with suspected sexual abuse, may perform an external genital exam. However, if there is enough suspicion to warrant a sexual abuse examination, the physician should attempt to get the patient to a SART team as soon as possible for the forensic examination. The clothing, underwear, diaper, pad, and sheets may contain evidence and should be brought with the victim to the examination site.

RECOMMENDATION

How should a medical director and his or her staff approach a possible sexual abuse case such as Ms. A? The medical director and staff must be informed to respond appropriately to suspected sexual abuse cases. This response may include medical, legal, forensic, administrative, risk management, and mental health aspects. In this case, the medical director would best serve the patient and the team by visiting the patient, reviewing the medical record, and performing a history and physical examination. The patient may not be able to provide details about bruises but the patient should be interviewed and any behavioral indicators should be elicited from the team and documented. The medical director should review any recent visitors or visits by other residents. Additionally, other residents should be questioned as they may be potential witnesses to sexual abuse. The medical director should make a report to the proper authorities (in this case, Adult Protective Services or the ombudsman) and the director of the long-term care facility should be informed. After evaluating the pattern and location of bruises as well as the history, if there is suspicion that sexual abuse has occurred, law enforcement should also be contacted. The patient may be sent to a SART team for a forensic sexual abuse examination with law enforcement approval. They may be transported for this examination either by ambulance or with law enforcement, depending on the extent of injury. A member of the team should contact the patient’s family and a family member may be allowed to accompany the patient for the sexual abuse examination. The primary care physician should also be notified about the clinical findings and the actions taken by the health care team. The medical director and staff should set up a plan to completely protect the patient from any further trauma or sexual victimization in the future.

The medical director, as the leader of the health care team, should examine all details of the case with the team, including the team’s response. The team should determine what was done correctly and where there is room for improvement. These lessons can be integrated into a facility policy and may be instrumental in developing strategies to prevent sexual abuse. All nursing homes and elder care facilities should have protocols regarding the collection and preservation of evidence as well as the response to the victim. Staff should be encouraged to document clearly all observations regarding a sexual abuse incident as these statements may be very helpful in an investigation. Additionally, facilities should develop measures to prevent sexual abuse. As sexual abuse can occur from one resident to another within a facility, the team should develop strategies for recognizing potentially abusive behavior and dealing with high-risk residents. Prevention may also include screening all employees for a history of abuse or criminal background. The medical director must ensure that all staff providing care to elders be educated about sexual abuse, including signs, symptoms, and appropriate responses.

SUMMARY

Sexual abuse of vulnerable adults is a devastating problem with significant physical and psychological consequences for its victims and their families. The medical director should be aware of the vulnerability to sexual abuse of elderly and disabled adults and be able to recognize potential physical and behavioral indicators. As the leader of a multidisciplinary
team, the medical director should provide education regarding
detection and reporting to all staff members. The team should
also develop strategies to aid in the prevention of sexual abuse
and the protection of their patients. Through the implementa-
tion of these measures, the medical director will help to
ensure the increased awareness of sexual abuse and provide
safeguards to those most vulnerable.

REFERENCES
2. Holt MG. Elder sexual abuse in Britain: Preliminary findings. J Elder
4. Sobsey D, Doe T. Patterns of sexual abuse and assault. Sex Disabil
6. Speaking the unspeakable: An interview about sexual assault with
   preventelderabuse.org/nexus/hrklawsnik.html.
7. Ramsey-Klawsnik H. Elder sexual abuse perpetrated by residents in care
8. Teaster PB, Roberto KA. Sexual abuse of older adults: APS cases and
10. Dyer CB, Connolly MT, McFeeley P. The clinical and medical forensics
    of elder abuse and neglect. In: Bonnie RJ, Wallace RB, eds. Elder
    Mistreatment: Abuse, Neglect, and Exploitation in an Aging America.
    Panel to review Risk and Prevalence of Elder Abuse and Neglect.
    Committee on National Statistics and Committee on Law and Justice,
    Division of Behavioral and Social Sciences and Education. Washing-
11. Teitelman J, Copolillo A. Sexual abuse among persons with Alzheimer’s
    disease: Guidelines for recognition and intervention. Alzheimer’s Care
12. Burgess AW, Brown K, Bell K, Ledray LE, Poarch JC. Sexual abuse of
    older adults: assessing for signs of a serious crime—and reporting it. Am J
13. Lichtenberg PA. A Guide to Psychological Practice in Geriatric Long-
14. Burgess AW, Dowdell EB, Brown K. The elderly rape victim: Stereo-
    types, perpetrators, and implications for practice. J Emerg Nurs 2000;26:
    516–518.
17. Ramsey-Klawsnik H. Elder sexual abuse perpetrated by residents in care
18. Hanrahan NP, Burgess AW, Gerolamo AM. Core data elements tracking