

# **SEXUAL ABUSE OF VULNERABLE ADULT POPULATIONS: GUIDELINES FOR NURSING HOMES, ASSISTED LIVING PROGRAMS AND RESIDENTIAL CARE FACILITIES**

## **INTRODUCTION**

“Sexual abuse or exploitation” means contact or interaction of a sexual nature involving an incapacitated or dependent adult without that adult’s consent. “Sexual abuse or exploitation” may also include being pressured to engage in sexual activity. Included in this definition is sexual contact with persons who are not able to communicate their unwillingness.

Sexual involvement by care providers or mental health professionals with their clients is inappropriate, exploitive, and is always illegal whether or not the adult consents. Sexual abuse occurs whenever force or coercion is used, even if the perpetrator is a resident of the facility or a spouse or partner of the resident being abused.

***Do not wait until an assault actually occurs to learn the correct procedures. Having this information on hand will decrease the time it takes for the resident who has been sexually assaulted to receive assistance. The first response to this person can significantly help or hinder recovery from the trauma of sexual assault. Sexual assault is an aggressive act that puts the victim/survivor in a potentially life-threatening situation, and causes emotional trauma. Remember that attempted rape has the same psychological consequences as a completed rape.***

Persons with developmental disabilities are more vulnerable to the crime of sexual assault than the general population. They are praised for their compliance, making them easily led or persuaded by others. They often have not been educated about safety, appropriate sexuality, or basic rights, and go to great lengths to be accepted. They also rely heavily on caregivers and live in high-risk environments.

Residents who were sexually abused as children or in other settings, may be retraumatized when they enter a new facility, or by events at a facility. Some “triggers” that may suggest earlier sexual abuse, and may cause retraumatization, include:

- Being out of control in a situation
- Derogatory or insensitive comments about sexual assault victim/survivors
- Television and movie violence
- Seeing someone who looks like assailant
- People touching or standing close without permission
- Being hugged or touched by any adult
- Being in a vulnerable position or situation
- Sexual advances
- Reading or hearing about other sexual assaults
- Feeling that people are staring
- Action, smell, sound, that reminds client of the assailant or the place where assaulted

## **HOW TO RECOGNIZE POSSIBLE SEXUAL ABUSE**

### **Signs that sexual abuse may have occurred recently:**

- Bruises in genital area
- Genital discomfort
- Sexually transmitted disease

- Signs of physical abuse (bruising, cuts, pains)
- Torn or missing clothing
- Unexplained pregnancy
- Avoidance of specific settings or individuals
- Withdrawal
- Sleep disturbances
- Regression
- Headaches
- Excessive crying spell
- Noncompliance

**Signs of possible past sexual abuse:**

- Depression
- Sleep disturbances
- Response to “triggers”
- Substance abuse
- Atypical attachment
- Noncompliance
- Seizures
- Poor self-esteem
- Eating disorders
- Resisting examination, either medical or dental
- Self-destructive behavior
- Learning difficulty
- Sexually inappropriate behavior

**Other possible indicators that sexual abuse has occurred:**

- Devaluing attitudes by caregiver toward resident
- Isolation of social unit
- Other forms of abuse (physical, emotional)
- Seeks isolated contact with children
- Strong preference for children
- Surrogate caregivers
- Pornography usage

## HOW TO RESPOND TO POSSIBLE SEXUAL ABUSE

**Immediate steps to be taken if the assault occurred within the past seventy-two hours:**

1. Take the resident to the hospital emergency room as soon as possible after the assault. Notify the guardian or durable power of attorney, if applicable. If the resident has a guardian, the hospital shall seek the guardian’s permission to provide medical treatment. If a guardian refuses to give permission for medical treatment, a report must be made to the Bureau of Elder and Adult Services.

The medical exam is essential to provide treatment for injuries, gather evidence for possible legal use, and to screen for sexually transmitted diseases and pregnancy. Residents are entitled to a complete rape

protocol exam, which is important, since the resident may be too embarrassed or unable to tell everything that happened; however, a resident may refuse to have a complete exam. ***Request that the resident not change clothes, wash, douche, go to the bathroom, or have anything to drink or to rinse her/his mouth before the medical exam. The medical exam is also a collection of forensic evidence for possible court proceedings, and will probably require as many as four hours for completion, a process that cannot be interrupted once it has begun.***

2. Call the appropriate authorities and resources: (telephone numbers on last page)
  - If the resident is an incapacitated or dependent adult, a report must be made to DHS, Bureau of Elder and Adult Services (BEAS). When BEAS is called, a caseworker may call law enforcement to begin an investigation.
  - If the resident is served in any capacity by DBDS, a sexual assault is considered a *critical incident*. The Regional Director for the area where the assault occurred must be called.
  - Call the statewide sexual assault center hotline. Resident consent for the call should be obtained if possible. A sexual assault center advocate can serve as a designated person to whom the resident and/or caregivers can direct concerns about the assault and its aftermath. The advocate will be knowledgeable about the legal system, medical procedures, and needs of the resident, and can serve as a resource for facility staff as well as the resident. An advocate can be present during the medical exam if the resident and/or guardian agree.
  - The resident has ninety days in which to decide whether to report the crime to the local law enforcement department. Evidence collected during the medical exam is held for this period of time by a designated agency in collaboration with the hospital where the exam is performed.
  - Residents may self-refer to any of the above authorities and resources.
3. ***Do not touch or disturb the scene of the assault, or remove any items.***
4. Remove the alleged perpetrator from contact with the client. It is usually recommended that a facility separate the client and alleged perpetrator pending the outcome of an investigation. Both parties may need protection. A person known to the client, such as a family member, caregiver, bus driver, etc, perpetrates the majority of assaults against people with disabilities. It is preferable to remove the perpetrator rather than the client so as not to reinforce victim blaming.
5. If more than seventy-two hours has elapsed since the assault, physical evidence cannot be collected, but medical attention for the client should be obtained.

**Further steps to be taken for the comfort and safety of the client:**

1. Do not leave the client alone.
2. Offer the client a blanket or something warm to wrap up in.
3. Make no comments implying that the client “asked for it” or is lying. Let the client know that she/he is believed, that the assault was not her/his fault, and that she/he did not cause it to happen. Often a victim/survivor blames her or himself for a sexual assault because of something she or he did or did not do. Reassure the client that only the perpetrator is to blame for an assault.
4. Find something in the client’s story to praise and support. The client may have done something brave, such as yelling or fighting back, but just living through an attack deserves praise. Do not suggest what should have been done, as this undermines self-esteem.

5. Help the client identify feelings about the experience by acknowledging the right to be angry, sad, hurt, or confused. Working through feelings is difficult, especially when the client knows the perpetrator.
6. Some clients want to talk about the incident repeatedly, and some prefer not to talk about it at all. Let the client know that someone is there to listen, and let the client guide how much is said about the incident.
7. Help the client decide on a problem-solving plan for dealing with the incident. It is important for the client to choose a plan, if at all possible, in order to regain control. Self-determination is the guiding principle, unless the client's plan represents a danger to the client or to another person.

### **SELF-PROTECTION FOR ALL CLIENTS**

1. Help clients learn to trust their feelings about being pressured to have sex
2. Help clients understand that they have the right to set sexual limits
3. Encourage clients to practice communicating those limits:
  - Okay to be rude to someone who is using sexual pressure, even if feelings are hurt
  - Okay to get angry when someone does something that is unwanted
  - Okay to yell, leave, push or use other means to get away
  - Okay to question behavior that doesn't seem right, such as sitting or standing too close, blocking the way, grabbing or pushing, disregarding "NO", staring

### **WHAT TO SAY, AND WHAT NOT TO SAY, TO SOMEONE WHO HAS BEEN SEXUALLY ASSAULTED**

When trying to support a client who has been sexually assaulted, try not to be judgmental or take control. Recognize how personal values, prejudices and experiences have an impact on the response to a client's sexual assault. A sympathetic ear can make a big difference in the recovery process.

#### **Communicating the following four points is most important:**

1. **"I'm glad you're alive."**
2. **"It's not your fault."**
3. **"I'm sorry it happened."**
4. **"You did the best you could."**

It is also helpful to keep in mind these guidelines:

#### **DO**

- be a good listener
- assist the client in getting the help she or he needs and wants, which may mean providing phone numbers, information, transportation, referrals

#### **DON'T**

- give advice or make decision for the client, remembering that it is important for the person who has been sexually assaulted to make her/his decisions as a step in regaining control and overcoming feelings of

helplessness

**DO**

- if the client feels guilty because she or he didn't fight back, tell her or him that fear often inhibits people, and that cooperation does not mean consent

**DON'T**

- ask why she or he didn't scream, fight, run
- make suggestions about what could or should have been done

**DO**

- try to minimize the number of times the client must tell the story of the assault

**DON'T**

- prevent the client from talking about the assault if she or he wants to

**DO**

- assure the client that it was not her or his fault, that no one asks to be sexually assaulted, and that no one deserves to be sexually assaulted

**DON'T**

- ask the client if she or he did anything to "lead the perpetrator on"
- ask the client what she or he was wearing
- ask the client any questions that begin with the word "why"

**DO**

- help the client to know that this experience will cause a disruption in her or his life but that recovery is possible
- ask permission before standing close to the client or touching her or him

**DON'T**

- stare
- blame the client for what happened

## IMPORTANT TELEPHONE NUMBERS

Maine Coalition Against Sexual Assault (MeCASA) 1-800-871-7741  
Connects to local area center

Department of Human Services (DHS) Intake 1-800-624-8404

Department of Behavioral & Developmental Services (BDS)  
Region I Director, 822-0274  
Region II Director, 287-4272  
Region III Director, 941-4762

**Information regarding training for staff and/or residents is available through the numbers listed above.**

*Guidelines developed as a collaborative effort by Karen Elliott, Bureau of Elder & Adult Services, DHS; Ann Jennings, Trauma Services, DBDS Office of Program Development;  
Kathy Walker, Rape Response Services*