University of Idaho
School of Health and Medical Professions

Project ECHO

When Safety Is Compromised

Dementia-informed responses to sexual assault and other forms of abuse

When the person with dementia is harmed

When the person with dementia causes harm

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BEFORE WE BEGIN

A note on a sensitive topic

This material may be hard to sit with

We'll discuss sexual assault, abuse, and trauma involving people who are highly vulnerable.

This work touches many of us personally as well as professionally. Step away if you need to.

Our aim is practical and compassionate — not graphic. The two cases are deidentified and some changes were made to ensure confidentiality.

The evidence base is uneven

The victim side is better studied, though still under-researched.

When the person with dementia is the one causing sexual harm, the literature is especially thin: few studies, small samples, little guidance and no approved treatment.

Where evidence is limited, we can lean on clinical judgment, ethics, and care principles.

Take what's useful, hold the rest gently, and bring your questions to the discussion.

WHY THIS SESSION

A dual-fold safety problem

The person with dementia as victim

Higher risk, lower detection. Cognitive impairment blocks disclosure and undermines credibility.

The person with dementia exhibiting harm

Disinhibition and misidentification can drive harmful behavior — without criminal intent.

42.6%

of persons with dementia experience abuse — psychological abuse most common

Sun et al., 2023 — 30-study meta-analysis

12.8% vs 62%

abuse reporting rate: victims with dementia vs without

Burgess & Phillips, 2006

~6 in 10

elder sexual-abuse victims in investigated cases had dementia

Burgess & Phillips, 2006

LEARNING OBJECTIVES

By the end of this session, you can…

Recognize

behavioral indicators of abuse and sexual assault in persons with dementia who cannot verbally disclose in community and facility settings.

Respond

with dementia-informed, trauma-informed strategies: immediate safety, reporting pathways, and ongoing care that doesn't depend on narrative memory.

Manage

harmful or sexually inappropriate behavior by a person with dementia in ways that protect others while preserving dignity and avoiding criminalization.

CASE STUDY 1 · COMMUNITY

Margaret, 82

Margaret has moderate Alzheimer's disease and lives at home; her adult son is her primary caregiver. A home health aide notices bruising on her inner thighs and that Margaret has begun to cry and resist during personal care — new behaviors. **When a "family friend" who visits frequently is mentioned, Margaret becomes agitated and says, "Don't let him in. Don't let him in."** She cannot describe any event when asked directly, and moments later does not recall the conversation.

What do you notice?
What would you do first and what makes this harder because it's a home, not a facility?

RECOGNITION

When words fail, behavior is the disclosure

Physical signs

Unexplained bruising (inner thighs, breasts, genital area), genital pain or bleeding, STIs, torn or stained clothing, poor hygiene or unmet needs.

Care-task reactions

New fear, crying, or combativeness during bathing, toileting, or perineal care; refusing care from a specific person.

Mood, sleep & regression

Nightmares, new startle response, withdrawal, agitation, regression, or decline with no medical explanation.

Relational cues

Distress tied to a specific person, place, or time of day; caregiver who hovers, isolates, or answers for the person.

A change from baseline is the signal. You must know the baseline to see it.

BARRIERS

Why detection and justice break down

- **Memory loss ≠ no trauma.** Emotional and somatic memory persist after narrative memory fades.
- **The "unreliable witness" problem.** Fragmented or delayed disclosures get discounted; suspects are less likely to be arrested or charged when the victim has dementia.
- **Ageist bias reaches the jury.** A "warm but incompetent" view of older victims with dementia predicts mock jurors' verdicts — bias, not evidence.
- **Symptoms get misattributed.** Fear and agitation are logged as "behaviors" of dementia — and sometimes medicated — instead of investigated.
- **Discovery is delayed.** Evidence degrades and forensic exam windows close before anyone suspects.

12.8%

of elder abuse victims with dementia ever report

vs 62%

of victims without dementia

Burgess & Phillips, 2006 — 284-case review

FIRST 24–72 HOURS

First response: safety, evidence, reporting

1 · Safety first

Separate from the suspected abuser. No unsupervised contact "in the meantime." Address urgent medical needs.

2 · Medical & forensic

Prompt exam; request a SANE (Sexual Assault Nurse Examiner) where available. Treat injuries, STI evaluation, document findings.

3 · Report

Mandated: APS in the community; in facilities, administrator + state survey agency + ombudsman. Law enforcement for assault.

4 · Document, don't interrogate

Record verbatim statements and observed behavior. Facts, not conclusions. Minimize repeated questioning; use forensic interviewers trained in cognitive impairment.

COMMUNITY SETTINGS

What makes home harder

- **Fewer eyes.** No ombudsman, no surveyors, no shift change. A home health aide or PCP visit may be the only outside contact.
- **Most of it happens here.** An estimated 80–90% of elder sexual abuse occurs in the home where it is least likely to be detected.
- **The abuser is usually known and often trusted.** Family members, "friends," paid caregivers. Sometimes the abuser is the care plan.
- **Access control.** The suspected abuser may control the door, the phone, the finances, and the story.
- **APS leads but needs partners.** Coordinate APS + law enforcement + medical. Safety planning may mean emergency respite or placement, protective orders, or guardianship review.

Coordination Needed:

- Home health aides
- Primary care & clinic staff
- Meal delivery & transport
- Faith communities
- Neighbors & family

HEALING

Trauma-informed care when memory fails

Traditional trauma therapy assumes a narrative. Dementia-informed trauma care targets felt safety instead of verbal processing.

Safety Focus

Consistent caregivers, predictable routine, familiar objects, calm sensory environment. Safety is experienced, not explained.

Adapt triggering care

Bathing or perineal care can re-enact the assault. Same-gender caregivers, narrate before touch, seek assent, pause when distress rises.

Follow, don't force

Never push for recall or "correct" fragments. Validate emotion in the moment; comfort with music, presence, touch (when welcomed).

Support the circle

Family and care staff carry secondary trauma. Debrief, support, and watch for their avoidance of the survivor.

CASE STUDY 1 · RESOLUTION

Margaret: the dementia-informed response

- Aide documented observations verbatim and reported the same day → APS + law enforcement; SANE exam completed within the forensic window.
- The "family friend" was barred from the home; son engaged in the safety plan. Locks changed, visit log started, aide hours increased.
- Care adapted: female aides only, care narrated before touch, bathing routine rebuilt slowly around Margaret's assent.
- Fear at bath time was treated as communication, not "agitation”, no antipsychotic started.
- Margaret stayed in her home. Prosecution proceeded on physical evidence and the aide's documentation, not on Margaret's testimony.

The aide's ordinary documentation became the extraordinary evidence.

CASE STUDY 2 · FACILITY

Frank, 78

Frank has frontotemporal dementia and has lived in a memory care unit for eight months. Staff report escalating sexual comments, then an incident of grabbing a CNA. He was also found in the bed of another resident, a woman with advanced Alzheimer's who cannot consent and was found crying. **Her daughter is demanding Frank be "arrested or kicked out." Frank's wife is devastated: "He was never like this. This isn't him."**

Who is our patient here? What do you owe each person in this scenario — Frank, the other resident, both families, the staff?

UNDERSTANDING

Symptom, not intent …but real harm

- **Disinhibition.** Damage to frontal systems removes the brakes — especially in frontotemporal dementia.
- **Misidentification.** He may sincerely believe the other resident is his wife. The behavior can be affectionate in his reality and assaultive in hers.
- **Unmet needs.** Loneliness, boredom, and the need for touch and intimacy don't end at diagnosis.
- **The law assumes an intent that dementia has erased.** Yet the impact on the other person is real and must be treated as such.

2–17%

of persons with dementia exhibit inappropriate sexual behavior

Lane et al., JAGS 2025

22.5%

of memory-care residents experience resident-to-resident aggression monthly (vs 10.3% in other units)

Pillemer et al., JAMA Netw Open 2024

ASSESSMENT

Find the driver before choosing the fix

Rule out acute causes

Delirium, UTI, pain, constipation, new or changed meds (dopaminergic agents, benzodiazepines).

Chart the pattern

ABC charting: when, where, with whom, what preceded. Clustered at evenings? During care? One target or anyone?

Name the behavior type

Intimacy-seeking vs disinhibited vs misidentification…each points to a different intervention.

Assess capacity & consent, both ways

Not all sexual expression is abuse; intimacy is a right too. Ask: can each person understand, agree, and disengage? Use structured consent assessment, not a blanket ban or a blind eye.

IMMEDIATE RESPONSE

In the moment: protect both people

The person harmed

- Calm separation; medical evaluation
- Notify their family and physician
- Their trauma is real even if they can't recall it
- Comfort plan and monitoring for delayed distress

The person with dementia

- Redirect calmly and matter-of-factly ….no shaming, scolding, or confrontation
- Increase supervision immediately (line of sight) while assessment proceeds
- Report anyway: facility incident reporting and state notification still apply
- Never conceal to spare the facility or the family

BEYOND THE INCIDENT

Care planning and the legal gray zone

THE CARE PLAN

- Environmental first: room placement, line-of-sight supervision, structured engagement in trigger windows
- Meet the underlying need: activity, meaningful roles, appropriate touch (hand massage, dance, pets)
- Behavioral approaches before medication
- Pharmacology last: no FDA-approved drug for inappropriate sexual behavior; evidence is limited…weigh harms, document consent

THE LEGAL GRAY ZONE

- Reporting duties don't vanish because the person who caused harm has dementia
- If police or APS engage, advocate for diversion to treatment… capacity evaluation, not jail
- Resist reflexive discharge: the facility owes a duty to both residents; transfer trauma is real
- Care conference with both families; ombudsman and ethics consultation early

CASE STUDY 2 · RESOLUTION

Frank: resolution without criminalization

- State report filed same day; both families notified. The other resident received a medical exam, comfort plan, and monitoring — her harm was named, not minimized.
- Work-up: UTI negative, but med review flagged a recently started dopamine agonist → tapered.
- ABC charting showed incidents clustered 6–8 pm…the low-staffing, low-stimulation window. Structured evening engagement added; rooms relocated to opposite wings; 15-minute checks.
- Care conference with both families; APS and police consulted — capacity evaluation supported diversion to care, no arrest.
- Six weeks later: no further incidents. Frank stayed. So did she.

Accountability and compassion ran on parallel tracks — neither canceled the other.

PULLING IT TOGETHER

One incident, two tracks — run the right one (or both)

Suspicion or witnessed incident

Person with dementia was harmed	Person with dementia caused harm
Safety: separate from suspected abuser; urgent medical needs	Protect the person harmed (run left track for them); redirect without shaming
Report: APS (community) / admin + state agency + ombudsman (facility); police if assault; SANE exam	Report anyway; increase supervision now
Document facts & verbatim words; minimize re-interviewing	Assess: delirium, UTI, meds, pain; ABC pattern; capacity/consent
Trauma-informed care plan: felt safety, adapted care, monitor	Intervene: environment & engagement first, medication last; care conference

TAKEAWAYS

Both sides of the same coin

1. Behavior is communication — on both sides of the incident.
2. Report facts. Don't adjudicate intent — that's not your job, and it delays protection.
3. Memory loss is not immunity from trauma, and it is not proof of guilt or innocence.
4. Protect the vulnerable without discarding the person with dementia.
5. Every "perpetrator" case contains a victim case. Run both tracks.
6. No one responds alone: medicine + nursing + social work + APS/law enforcement + family.

DISCUSSION

Your cases, your settings?

- Think of a case where behavior was the only disclosure. What did you notice and what almost got missed?
- What barriers exist in your setting to reporting … especially resident-to-resident or family-perpetrated incidents?

Resources

- Adult Protective Services (state hotline)
- Long-Term Care Ombudsman
- Natl. Center on Elder Abuse — ncea.acl.gov
- Eldercare Locator — 1-800-677-1116
- RAINN Hotline — 1-800-656-4673
- Alzheimer's Assn 24/7 — 1-800-272-3900

References

Abuse prevalence in dementia (42.6%)

Sun, F., Zhang, X., et al. (2023). Prevalence of Elder Abuse and Neglect of Persons with Dementia in Community Settings: A Systematic Review and Meta-Analysis. Innovation in Aging / GSA.

Reporting gap (12.8% vs 62%); ~6 in 10 with dementia; ~80–90% at home

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Resident-to-resident aggression (22.5% memory care vs 10.3%)

Pillemer, K., Lachs, M. S., Teresi, J. A., et al. (2024). Estimated Prevalence of Resident-to-Resident Aggression in Assisted Living. JAMA Network Open, 7(5).

Inappropriate sexual behavior (2–17%) and treatment evidence

Lane, et al. (2025). Treatment of Inappropriate Sexual Behavior in Persons With Dementia: A Systematic Review. Journal of the American Geriatrics Society.

Juror bias against victims with dementia; ~80–90% at home

Syme, M. L., & Cohn, T. J. (2020). Elder Sexual Abuse and Implicit Agism: Examining the Warm-Incompetent Bias Among Mock Jurors. Journal of Elder Abuse & Neglect, 32(1), 1–26.

Sexuality as a right; limits of a safeguarding-only stance

Grigorovich, A., Kontos, P., et al. (2022). Dementia and Sexuality in Long-Term Care: Incompatible Bedfellows? Dementia, 21(4), 1077–1097.

Abuse risk rises with dementia severity and agitation

Rababa, M., Eyadat, A., et al. (2025). Elder Abuse and Associated Factors among Nursing Home Residents with Dementia. Ageing International, 50, 27.

Reporting pathways and practice resources

National Center on Elder Abuse (NCEA), Administration for Community Living — ncea.acl.gov. Adult Protective Services and Long-Term Care Ombudsman programs, by state.