

The Comprehensive Sexual Assault Assessment Tool:  
Variations and Uses of a Roy Adaptation Model-Based Assessment Tool

Ann W. Burgess, RN, DNSc, APRN, FAAN

Professor, William F. Connell School of Nursing

Boston College

[ann.burgess@bc.edu](mailto:ann.burgess@bc.edu)

Jacqueline Fawcett, RN, PhD, ScD (hon), FAAN, ANEF

Professor, Department of Nursing

University of Massachusetts Boston

[jacqueline.fawcett@umb.edu](mailto:jacqueline.fawcett@umb.edu)

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### Abstract

The purposes of this paper are to explain the development of the Roy Adaptation Model-based Comprehensive Sexual Assault Assessment Tool (CSAAT), first published in 1995; to describe the use of the CSAAT and its variations, and to apply the CSAAT to two contemporary cases of sexual assault. One case is a 76-year-old deaf and mute woman who was raped while hospitalized due to a medical diagnosis of pneumonia. The other case is a 40-year old woman who was sexually assaulted by an anesthesiologist during hospitalization for orthopedic surgery. Application of the CSAAT to the two women demonstrates how the concepts of the Roy Adaptation Model, including focal and contextual stimuli and the physiological, self-concept, role function, and interdependence modes of adaptation, provide a comprehensive format for assessing the experiences of victims of sexual assault and facilitates identification of the level of adaptation (integrated, compensatory, compromised) attained by victims.

Nurses have historically been on the cutting edge of identifying and reporting sexual assault in their practice domains. Nurses, early on, were aware of the problem and knew the protocol for reporting and collecting evidence. No case made this point more effectively than the William E. Miofsky case of the sexual abuse of anesthetized patients in the 1970s. In that case, a circulating nurse witnessed the anesthesiologist with his penis in a patient's mouth. The nurse, shocked by that she saw, asked another circulating nurse to verify her observation. Both nurses reported their observations to the operating room nursing supervisor, but when the three nurses met with the surgeon after the surgery and examined the stains on the drapes, the surgeon did not believe their account, did not order lab tests on the stained material, and told the nurses not to discuss the matter (Mertz, 1986). Although the supervising nurse then reported the incident to the head of anesthesiology, in a confrontation the anesthesiologist denied the charges, and no further reports were made.

The first circulating nurse continued to witness suspicious behavior by the anesthesiologist. She discussed her concerns with the supervising nurse, and the allegations were relayed to the hospital administrator and the president of the hospital board of trustees; however, no action was taken. The operating room nurses were not deterred. Two years later, after observing suspicious movements by the same anesthesiologist with a 12-year-old patient, the nurses gathered a specimen of secretions from the patient's suction tubing to test for the presence of semen. They prepared a report, submitted it to the administrator, and received no response. The nurses then took their report to the state medical licensing board. With forensic evidence, the anesthesiologist could not deny his deviant behavior and resigned. The state medical quality assurance board and the board of registered nursing moved to suspend the licenses of three doctors and two nurses for gross negligence and unprofessional conduct in

failing to investigate and report the offenses that had gone on for over 3 years. (For a full account of the incident see Mertz (1986) and for an update about the anesthesiologist see Locke (2017)).

### **The Comprehensive Sexual Assault Assessment Tool and its Derivatives**

More than 20 years ago, Burgess and colleagues (1995, 1996) published two versions of the Comprehensive Sexual Assault Assessment Tool (CSAAT). The CSAAT was designed to provide health professionals, especially sexual assault nurse examiners (SANEs) with a standardized and comprehensive method to document an incident involving sexual assault and/or rape. Development of the CSAAT was guided by Roy's Adaptation Model (RAM; Roy & Andrews, 1991). RAM provides a comprehensive schema for assessing the experiences of sexual assault victims and facilitates identification of the level of adaptation attained by the victim (integrated, compensatory, compromised). RAM concepts and their definitions are listed in Table 1.

Table 1  
*Roy's Adaptation Model Concepts and their Definitions with Examples of CSAAT Items*

<b>Roy Adaptation Model Concepts and Definitions</b>	<b>Examples of CSAAT Items</b> <b>IA = Initial assessment</b> <b>FUA = Follow-up assessment</b>
Focal Stimulus "The internal or external environmental stimulus most immediately confronting the [person]" (Roy, 2009, p. 63)	Time and date of the rape/assault (IA)
Contextual Stimuli "All other internal or external [environmental] stimuli affecting the situation" (Roy, 2009, p. 63)	Type and sequence of sexual acts ((IA) Offender method of approach (IA) Offender control of victim (IA)
Regulator Coping Process A coping process that "responds through neural, chemical, and endocrine coping channels" (Roy, 2009, p. 41)	Victim vital signs (IA) Post traumatic stress disorder assessment— exaggerated startle response, other symptoms since the assault, such as increased heart rate (FUA)

<p><b>Cognator Coping Process</b> A coping process that involves “four cognitive-emotive channels: perceptual and information processing, learning, judgment, and emotion” (Roy, 2009, p. 41)</p>	<p>Victim actions following the assault (IA) Post traumatic stress disorder assessment— involuntary intrusive thoughts, recurrent upsetting dreams, flashback episodes (FUA)</p>
<p><b>Physiological Mode of Adaptation</b> “The manifestation of the physiologic activities of all the cells, tissues, organs, and systems comprising the human body” (Roy, 2009, p. 90), including oxygenation; nutrition; elimination; activity and rest; protection; senses; fluid, electrolyte, and acid-base balance; neurological function; and endocrine function</p>	<p>Genital trauma (IA) Post traumatic stress disorder assessment— physiological distress to trauma cues, other symptoms since the assault, such as changes in appetite (FUA)</p>
<p><b>Self-Concept Mode of Adaptation</b> Behavior “pertaining to the personal aspect of human systems” (Roy, 2009, p. 95). The physical self encompasses physical attributes, functioning, sexuality, health and illness states, appearance, body sensations, and body image; the personal self encompasses self-consistency, self-ideal, and the moral-ethical-spiritual self</p>	<p>Victim’s behavior during examination and interview (IA) Post traumatic stress disorder assessment— psychological distress to trauma cues, body image disturbance, low self-esteem (FUA)</p>
<p><b>Role Function Mode of Adaptation</b> Behavior—or activities—that are associated with ascribed and acquired roles (Roy, 2009)</p>	<p>Roles reflected by victim’s age, gender, education, marital status, occupation, employment status (IA) Post traumatic stress disorder assessment— decreased interest in role activities (FUA) <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM) multiaxial evaluation— social environment, occupational, educational, and economic problems (FUA)</p>
<p><b>Interdependence Mode of Adaptation</b> “Interactions related to the giving and receiving of love, respect, and value” (Roy, 2009, p. 45)</p>	<p>Victim’s living arrangements (IA) DSM multiaxial evaluation—primary support group and housing problems (FUA)</p>
<p><b>Adaptation Level</b> The effect of all environmental stimuli on the person; levels are integrated (“structures and functions of a life process are working as a whole to meet human needs” (Roy, 2009, p. 27)), compensatory (“cognator and regulator have been activated by a challenge to the integrated life processes” (Roy, 2009, p. 26)), and compromised (“inadequate integrated and</p>	<p>Determination of adaptation level is the SANE’s judgment about the extent to which the victim is adjusting to what happened initially (IA) and later (FUA), based on all CSAAT data</p>

compensatory life process; an adaptation problem” (Roy, 2009, p. 26))	
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### CSAAT-1995

The first version of the CSAAT (CSAAT-1995; Burgess, Fawcett, Hazelwood, & Grant, 1995) includes 174 items divided into four major areas: investigative data, victim forensic data, legal and services information, and psychosocial assessment for posttraumatic stress disorder (PTSD).

Investigative data encompasses:

- Basic victim background demographic and assault data
- Basic offense data
- Offender method of approach and behavior during the assault data

Victim forensic data encompasses:

- Victim physiological and laboratory data
- Victim post-assault data
- Rape examination findings
- Victim emotional states and responses

Legal and services information includes:

- Emergency response
- Forensic services
- Resource mobilization
- Suspect arrest
- Preparation for court
- Court appearance
- Sentencing process
- Post-sentencing

Psychosocial assessment for PTSD involves a multi-axial evaluation for PTSD symptoms following DSM guidelines. Inclusion of legal and services information and psychosocial assessment permits victim and offense follow-up.

Burgess et al. (1995) included no information about content validity testing or estimates of intra-rater or inter-rater reliability for CSAAT-1995. They also did not include any linkages of

CSAAT-1995 items with RAM concepts. Explicit use of the CSAAT-1995 has not been reported.

### **CSAAT-1996**

The second version of the CSAAT (CSAAT-1996; Burgess & Fawcett, 1996) includes 139 items for the same investigative data and victim forensic data areas as CSAAT-1995, although CSAAT-1996 does not include the follow-up areas of legal and services and psychosocial assessment. This is the only published version of the CSAAT that explicitly links RAM concepts with the CSAAT items. The linkage between the RAM concepts and examples of CSAAT items is displayed in Table 1. Burgess and Fawcett (1996) reported content validity testing of both CSAAT-1995 and CSAAT-1996 using a panel of sexual assault experts who were attending a SANE training workshop. However, no testing for intra-rater or inter-rater reliability estimates was done.

CSAAT-1996 has been used to code existing forensic data. Burgess and Hanrahan (2004) and Burgess, Hanrahan, and Baker (2005) reported results of use of CSAAT-1996 by attorneys, SANEs, police detectives, Federal Bureau of Investigation personnel, social workers, physicians, nurses, and administrators to code data from 125 cases of sexual assault. Burgess and Clements (2006b) used CSAAT-1996 for a retrospective record review of 284 cases of sexual assault of older adults; they were particularly interested in data about post-traumatic stress disorder. Although CSAAT-1996 was cited in these articles, the legal and services information and psychosocial assessment for posttraumatic stress disorder from CSAAT-1995 also was used for coding of the forensic data. Burgess and Phillips (2006) also used CSAAT-1996 data to identify and examine correlates of dementia among 284 older adults who had experienced sexual assault. In addition, Taylor (1998) included some areas of the CSAAT-1996 in her discussion of items that should be included in documentation of sexual assault.

### **CSAAT-Elder**

CSAAT–Elder (CSAAT-E) was developed specifically for assessment of sexual assault of older adults. CSAAT-E evolved from CSAAT-1995 by adding 19 items about the victim, including temporality, physical and mental status, injury severity, and assault outcomes (Hanrahan, Burgess, & Gerolamo, 2005). Hanrahan et al. (2005) noted that the addition of temporality before and after the assault “is perhaps the most significant revision of the CSAAT” (p. 416). They reported that content validity was tested by an expert panel of attorneys, SANEs, police detectives, Federal Bureau of Investigation personnel, social workers, physicians, nurses, and administrators. No testing for intra-rater or inter-rater reliability was done. Hanrahan and Burgess (personal communication to J. Fawcett, July 29, 2002) established linkages between CSAAT-E and RAM concepts. Burgess, Ramsey-Klawnsnik, and Gregorian (2008) used CSAAT-E to code and analyze data from 284 cases of sexual assault of older adults.

### **CSAAT-New Hampshire**

A 24-item CSAAT (CSAAT-New Hampshire), was developed as a clinically practical tool for collection of data from victims of sexual assault. No details about the areas or specific items included in this version are available, and nor are any links of items with RAM concepts available. The extent to which CSAAT-New Hampshire is used is not known beyond its use by New Hampshire SANEs to collect data from 741 adult females who had been sexually assaulted between January 1, 1997 and December 31, 2007. Murphy, Potter, Pierce-Weeks, Stapleton, and Wiesen-Martin (2011) reported the results of their analysis of these data. They explained that New Hampshire SANEs were trained to use this version of CSAAT, and that any items that were not sufficiently clear to the nurses during training were more fully described in the tool instructions. However, content validity of CSAAT-New Hampshire items or estimates of intra-



rater reliability were not reported, and Murphy et al. (2011) stated that no inter-rater reliability estimates were conducted.

### **Additional Literature**

A search of the literature included in the Cumulative Index to Nursing and Allied Health Literature (CINAHL Complete) in September 2018 for each of seven Burgess and colleagues' articles and a separate search for CSAAT as an instrument yielded the results given in Table 2.

Table 2  
*Citations to CSAAT*

Primary Source	Citation
Burgess & Fawcett (1996) (Search CSAAT-Instrumentation)	Burgess & Clements (2006b) Burgess et al. (2005) Burgess & Phillips (2006) Burgess et al. (2008) Hanrahan et al. (2005) Murphy et al. ((2011) Taylor (1998)
Burgess & Hanrahan (2004)	No citations
Burgess, Hanrahan, & Baker (2005)	Burgess & Clements (2006a, 2006b) Cooper & King (2006) Morgenbesser et al. (2006) Speak et al. (2013)
Burgess & Clements (2006b)	Amar & Clements (2008/2009) Mora (2008) Speak et al. (2013)
Burgess & Phillips (2006)	Brozowski & Hall (2010) Probst et al. (2011) McDonald et al. (2012, 2015)
Hanrahan, Burgess, & Gerolamo (2005)	Scriver et al. (2013)
Burgess, Ramsey-Klawnsnik, & Gregorian (2008)	Kent-Wilkinson (2010) Mukherjee (2011) Sullivan-Wilson & Jackson (2010)

### **Application of the CSAAT: Two Case Studies**

The case studies presented in this section illustrate how RAM concepts can be used to provide a conceptual context for data collected using CSAAT. The first case involves rape in a hospital. Sara is a 76-year-old female who is deaf and mute. On Thursday March 5, she was

admitted to a medical center for shortness of breath, which was later diagnosed as pneumonia. Upon her admission, nursing staff placed a hand written sign outside her hospital room indicating she is deaf and mute. The details of Sara's sexual assault and the consequences are described in Table 3.

Table 3  
*A Sexual Assault and Consequences: Sara's Experience*

Roy Adaptation Model Concept	Case Data
Focal Stimulus	On Friday morning, at approximately 3:00 a.m. or shortly thereafter, Sara was awoken by someone licking her ear.
Contextual Stimuli	The unknown assailant rolled Sara over on her back and sexually assaulted her with digital and penile penetration of the vagina. Shortly thereafter the unknown assailant fled the room.
Regulator Coping Mechanism	On Monday morning, Sara was discharged from the hospital. On Monday evening, Sara was found by her daughter crying at her home and reported the rape to her daughter. Law enforcement was notified of the rape. Sara's undergarments were turned into to the Police Department. DNA testing of the undergarments is pending.
Cognator Coping Mechanism	Sara was only able to disclose the rape to someone she regarded as safe--her daughter--after discharge from the hospital.
Physiological Response Mode	After reporting the rape, Sara was taken by her daughter to a hospital where a rape kit was performed by a SANE. The SANE report notes a 1 cm circular bruise on Sara's inner left thigh, and a 9 o'clock 1 mm circular abrasion to her labia minora--both consistent with a sexual assault. Sara was discharged at 3:14 a.m. Tuesday morning and issued a final discharge diagnosis of sexual assault.

Self-Concept Response Mode	<p>On Thursday, Sara followed up with her primary care physician, and was seen by the staff family nurse practitioner. Sara was complaining of vulvar pain and burning. The office note also indicates further reporting of the rape at the medical center. At this visit, Sara was diagnosed with vaginal irritation and vaginitis.</p> <p>Following the assault, Sara would all of a sudden burst into tears and pace around the house but she would never talk about it. When her daughter asked if she was okay, Sara would indicate “no.” Some days she would write that she would be okay in a minute, to let her have a minute. Sara’s crying and pacing had not occurred prior to the assault.</p>
Role Function Response Mode	<p>Sara’s persistent crying, fear of being alone, and fear of men created problems with her activities of daily living. The family have had to have someone with her at all times and have had to restrict some males from visiting her.</p>
Interdependence Response Mode	<p>The medical center and its staff have a duty to closely monitor, observe, and protect patients from harm. The medical center breached its duty and standards of care by failing to properly monitor, observe, and protect Sara from sexual assault.</p> <p>Additionally, the medical center nursing staff placed a sign outside the door of Sara’s room notifying everyone, including the general public walking along the hallway, that she was deaf and mute. Any sign intended to notify medical staff of her deaf and mute condition should have been privately placed inside her room. Posting this sign outside her room, which alerted the general public to her medical condition, is a violation of HIPPA and a clear breach of standards of care.</p> <p>Furthermore, the public posting that Sara is deaf and mute clearly puts any potential sexual predator on notice of Sara’s extremely vulnerable condition and acts as an invitation for assault.</p> <p>In addition, the rape occurred at approximately 3:00 a.m. The medical center clearly has an obligation to prevent anyone--patients or non-staff--from roaming the hallways at all hours of the night. If the unknown assailant was a non-staff person, the medical center and its staff had clearly breached their obligation to protect their patients and adhere to standards of care.</p>

Adaptation Level	Sara’s level of adaptation was compromised. She was not able to be left alone at any time due to her newly developed fears.
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The forensic questions related to Sara’s experience are:

- Did the medical center, its nursing staff, other employees, and/or agents fail to properly monitor, observe, and protect Sara from a sexual assault while hospitalized?
- Why did Sara not report the rape to a staff member?
- Why or how did the staff fail to observe Sara’s distress?
- To what extent did Sara’s being deaf and mute influence what happened to her and what was done after the sexual assault?

The second case occurred in a hospital surgical unit, specifically while the patient was sedated in a holding room prior to hip surgery. The rape was not realized by the patient, Megan, a 40-year-old female, until she was a patient at a rehabilitation center following orthopedic surgery. The details of Megan’s sexual assault and the consequences are described in Table 4.

Table 4  
*A Sexual Assault and Consequences: Megan’s Experience*

Roy Adaptation Model Concept	Case Data
Focal Stimulus	Megan, 40, was admitted for orthopedic surgery to her hip and then sent to a rehabilitation center. Two weeks into her rehabilitation she received a phone call from the anesthesiologist asking if she would like him to give her another nerve block massage.
Contextual Stimuli	The pre-surgery medication included Versed 1 mg, Fentanyl 50 mcg, and Propofol 10 mg, and conscious sedation and ultrasound were used. The block was administered by the anesthesiologist. His phone call to Megan triggered a memory of his doing rectal penetration while she was in the holding room prior to surgery.

Regulator Coping Mechanism	Megan became worried that the anesthesiologist would come to the rehabilitation unit, so she told the head nurse about the phone call, with the eventual outcome of police being called to interview Megan.
Cognator Coping Mechanism	The nursing staff followed through with their concern, resulting in police being called.
Physiological Response Mode	Physiological symptoms after the assault included increased heart rate and blood pressure, loss of appetite, difficulty sleeping, and Megan's statement of feeling "like an out of body experience."
Self-Concept Response Mode	Megan was seen for an acute visit by CNP for anxiety, excessively crying, and agitation. She requested to speak with a provider; stating that she was feeling very anxious after she realized that she might have been inappropriately touched by a doctor during her most recent surgery. She explained that a doctor whose name she could not recall came into her room to give her a nerve block; he gave her an extensive rectal exam and asked her many questions of a sexual nature regarding her sexual activity. Then, during her rehabilitation, the doctor called the facility to speak with her and asked her if she would like another nerve block and a massage. She denied these services and did not hear from the doctor again. She became concerned that she had been taken advantage of and was inappropriately touched. Over time, Megan has recalled fragmented pieces of memory of the sexual assault, which has increased her anxiety and depression. She is in counseling with a psychiatrist and talking about it is bringing back more memories.
Role Function Response Mode	Megan's experiences and memories have impaired her ability to concentrate, and focus, which have in turn diminished her motivation to perform simple tasks and impaired her ability to soundly.
Interdependence Response Mode	After an investigation, the anesthesiologist confessed and his medical license was revoked.
Adaption Level	Megan's level of adaptation was compensatory.

Megan's experiences were unfortunately typical of other victims with an altered mental status (in this case by anesthesia and medications), who can still experience trauma from sexual abuse and harassment. In such cases, the abuse memories are usually processed slower and take more time to be recovered. Megan's nursing diagnosis was compounded rape trauma, and her psychiatric diagnosis was PTSD and Major Depression Disorder, Severe Type. Megan had a pre-

existing orthopedic problem. Her physical health at the time of the rape was poor in that she was experiencing a high level of pain. The presence of her need for pain medication coupled with the medications for her surgery created the delayed and compounded aspect of the traumatic assault. Megan, prior to the sexual assault, was on a typical surgical course; however, the sexual assault tipped the balance of her medical condition, causing an increase in medications to control her anxiety, which negatively influenced her surgical recovery at the rehabilitation center. Rape trauma victims often develop fears and phobias to the circumstances surrounding the attack; Megan's fear of medical care is an example of this common aftermath symptom.

Memory has two levels--explicit or verbal and implicit or behavioral. Megan's explicit memory system was altered due to the anesthesia, although there was no indication that her implicit memory system was not functioning. She had fragmented memory of the sexual assault as well as behavioral changes. One of the most difficult psychological issues for Megan is whether she will ever have full recall or confirmation of the victimization by the anesthesiologist. Only two people know what happened—Megan and the anesthesiologist. Megan has to struggle with the uncertainty of the assault. This in and of itself has created an additional psychological issue for her. She is receiving individual therapy weekly and working with her counselor to bring some level of closure to the incident. Her prognosis is fair with consistent and continual counseling as she works through the history of her trauma.

Compounded rape trauma is a variation of rape trauma syndrome (Burgess & Holmstrom, 1974/2015) whereby victims with a past or current history of psychiatric or physical problems express primary symptoms but muting of rape trauma symptoms. Victims may not be able to tell others of the trauma-related thoughts they are having, such as involuntary repeated memories of the rape. Primary symptoms derive from the victim's initial diagnosis as a patient, such as Sara's breathing difficulties from the diagnosis of pneumonia.

## Discussion

Sexual assault continues to be a serious contemporary health issue for the person reporting rape and SANEs and other nurses assessing and treating that person. We applied the Roy Adaptation Model (2009) to two cases with similarities and differences in the victims' experiences. The similarities include that both assaults occurred on hospital property where the women were undergoing medical and nursing treatments, no witnesses observed the assaults, the patients were either unconscious or unable to hear or speak, and at least one of the two perpetrators was a hospital employee. Both cases involved delayed disclosure that prevented the collection of evidence from a rape kit, although one patient had genital bruising. The differences included one perpetrator who confessed, and one where the perpetrator was never apprehended. In both cases, nurses were involved in the forensic investigation and recording their interactions with the patients. It would have been ideal if the nurses had used a standardized data collection form based on a nursing conceptual framework to emphasize nursing's contribution to providing services to traumatized patients, such as a version of CSAAT.

Use of a version of CSAAT provides a systematic approach to data collection for victims of sexual assault. One use of CSAAT is as a guide for collection of data from victims of sexual assault. Another use is to code existing forensic data about sexual assault that typically are collected by legal and law enforcement personnel, as was done in most of the studies cited earlier in this paper.

The extent to which SANEs and other health care personnel are currently using a version of CSAAT is not known. Therefore, we recommend that an international study be conducted to determine use of any versions of CSAAT, as well as barriers to and facilitators of CSAAT use.

Placing CSAAT data in the context of RAM provides a nursing discipline-specific perspective. Use of RAM for this purpose provides the information needed to develop and

implement nursologists' interventions targeted to management of the focal and contextual stimuli (Roy, 2009). Evaluation of the effects of the interventions will provide needed information about the victim's level of adaptation.



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