

Sexuality and Dementia

October, 2010

Discussion of sexuality, and more precisely, intimacy in the older individual with dementia

- if you came for a "sex talk" you might as well leave right now
- instead, I hope that we can understand ourselves and our loved ones as sexual beings who need touch and intimacy and love
- the need for sexual intimacy does not end at any age, and those who pursue it or not inappropriate (although dementia may impair our understanding of what is appropriate)

General outline for the evening

- cultural understandings of sexuality
- typical changes in sexual function as we become older
- shifting focus of sexual needs
- sexuality in the individual with dementia
- questions and discussion

1. Cultural and societal patterns

- a. We are visually explicit about the human body and sexuality, but sometimes tongue-tied when it comes to talking about healthy sexuality
- b. It probably should be reversed.....
- c. Our conversation may be more direct and straightforward than you are used to. I invite you to set aside any embarrassment or hesitation -- and be willing to talk honestly about an aspect of human interaction that is essential to emotional health

2. What is "normal" -- there is a broad range and no one right answer

- a. sexuality and sexual activity continue well into later life
- b. sexual activity decreases with age, particularly among women, sexual activity in both men and women continues well into the senior years
- c. 24% of people over age 75 were having sexual relations more than twice per month

3. Age related changes

- a. men
 - i. decrease in the number of spontaneous and morning erections.
 - ii. rigidity of the erection diminishes,
 - iii. the force and volume of the ejaculate diminishes,
 - iv. faster detumescence.
 - v. The preejaculatory sensation also diminishes
- b. Women
 - i. increased vaginal atrophy and dryness
 - ii. increased arousal time
 - iii. requires more direct genital stimulation
 - iv. decreased duration of orgasm
- c. Diseases
 - i. Diabetes
 - ii. Arthritis
 - iii. heart disease
 - iv. Depression

- d. Medications
 - i. blood pressure medications
 - ii. antidepressants
- 4. Shift in focus
 - a. younger model: desire-arousal-**orgasm**-resolution
 - b. older model :
 - i. sexual arousal and response may focus more on Intimacy, bonding, commitment, love, affection, acceptance -> pleasurable resolution.
 - ii. orgasm may or may not play a part - rather a broader experience of intimacy.
 - iii. Shift from genital sex to intimacy, and other means to express lifelong sexual desires
 - iv. Any activity that involves affection, romance, intimacy, and companionship may help satisfy sexual needs of older adults
 - v. Study: Male residents of a nursing home were asked to rate various types of intimacy.

Highest<----->lowest
 Social, nonsexual-physical, intellectual, emotional, sexual-physical

- vi. Study: the major mode of sexual expression, as seen by residents, is trying to remain physically attractive
- vii. The role of noncoital sexuality assumes an ever-increasing importance in the infirm elderly, and caregivers must acknowledge the changing nature of sexuality as people age
- c. New language- another way to describe this change of focus
 - i. Youthful love: the “first language” of sex is biological, physically urgent, an exciting production
 - ii. Mature love: the “second language” of sex relies on using words, emotions, and caring
- 5. Sexuality and dementia
 - a. The need for tactile stimulation and physical closeness may remain important to the individual with dementia and for the partner
 - b. Sexual consequences during the early to moderate stages of dementia:
 - i. anorgasmia,
 - ii. erectile dysfunction,
 - iii. loss of libido
 - iv. mood disorders.
 - c. Later stages, the patient may fail to recognize his/her partner but may wish to continue the sexual relationship
 - d. Changing nature of the relationship
 - i. Partner/lover → caregiver (parent)
 - ii. Child → caregiver (parent)
 - e. Feelings of guilt in the partner who rejects the physical advances

- f. Caregiver recommendations
 - i. physical intimacy, touch, and physical closeness is appropriate throughout all stages of dementia
 - ii. But some individuals may become demanding and insensitive to the needs of others. There may be unreasonable and exhausting demands, often at odd times or in inappropriate places.
 - iii. Partner
 - 1. There is no right or wrong time when direct sexual contact should continue or stop.
 - 2. You should not participate in intimacy with which you are not comfortable
 - 3. You will need to make the decision when to set boundaries on sexual expression – you cannot count on your partner to be able to understand and decide on this
 - iv. Family members or caregivers –
 - 1. You may be the recipient of sexual intimacy. This can be especially distressing when it comes from a parent. In most settings this is not perverted or immoral, but rather the loss of ability to understand who they are with. It may be helpful to view this as their minds recollection of past healthy intimacy - they perceive you as a familiar person can interpret that as a partner rather than a child.
 - v. Suggestions for managing inappropriate sexual behaviours: (on handout)
 - 1. Consider all possible reasons for the inappropriate behaviour. These could include needing to go to the toilet, discomfort or boredom.
 - 2. Gently discourage inappropriate behaviour.
 - 3. Try to remain focused on the person, not the behaviour.
 - 4. Aim to distract the person if possible or redirect them to another activity.
 - 5. Find ways to include different forms of touch in the everyday routine, so that the person gets some physical contact. Massage, holding hands and embracing are ways of continuing to provide loving touch.
- g. Seeking intimacy outside of the marriage relationship
 - i. Sandra Day O’Conner
 - 1. when husband of 55 years began seeing another woman, former US Supreme Court justice Sandra Day O'Connor did not begin high-profile divorce proceedings or condemn his infidelity. She went public with the news that her husband John, 77, who suffers from Alzheimer's disease, had struck up a relationship with a woman patient at a care facility in Arizona.
 - 2. "Mom was thrilled that dad was relaxed and happy and comfortable living here, and wasn't complaining," one of the O'Connors' three sons
 - 3. An Alzheimer patient who embarks on a new relationship is not truly cheating on their marriage. "These relationships are not based on adultery or betrayal. Alzheimer's patients lose so much of their past and very often have no memory or recall of anything of their lives,

apart from their day-to-day experience. **They live in the moment without the luxury of their past lives,"**

6. Masturbation

- a. Often a difficult topic for family members
- b. Some religious or philosophical orientations may see it as inappropriate or wrong
- c. For some individuals it may be the only option for sexual release
- d. In the right setting, can be a healthy and appropriate expression of sexuality for individuals or couples.
- e. Focus less on the morality – more on the context and setting and appropriate privacy.

Handout for attendees -- below

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Dr. Kraybill's Principles

- 1) We are all sexual beings, have a need for sexual intimacy, and must find ways to express that sexuality. *The person who is denied touch, affection, or the connection with another human being slowly deteriorates and dies physically and emotionally.* Sexuality is good and God-given. It is how we express that that can cause problems.
- 2) Individuals with dementia lose their sense of appropriate social boundaries and behavior, including sexuality. We don't chastise them for memory loss, why should we be upset when they forget how to healthily express sexuality?
- 3) Caregivers are not expected to accept language, touching, or actions that are uncomfortable to them. When confronted with inappropriate sexual behavior, caregivers should respond with direct non-shaming personal statements such as, "Those are not appropriate actions/words and they make me uncomfortable. I will not be able to continue your care if you do that."
- 4) Caregivers should help to give feedback and education on sexual expression. Many forms of sexual expression may be appropriate in privacy but not in public. The best response to masturbation is not, "That's wrong," but rather, "That's something that should be private and here's how you can have that privacy."
- 5) When an individual with dementia has a living spouse, seeking intimacy with a third person should not be considered infidelity, but rather a reflection of the human wish for intimacy.

Questions to consider in determining if an individual with dementia can consent to sexual activity:

1. Is the dementia less than severe on cognitive screening tests?
2. Is the sexual behavior consistent with the individual's lifelong values, behaviors, and beliefs?
3. Does the individual have the ability and capacity to say "no" to any unwanted sexual advances?
4. Can the individual explain what sexual activities and behaviors she/he is comfortable participating in?
5. Does the individual recognize the other person involved? If this is a new relationship, does the individual realize that the relationship may be temporary?
6. Does the patient have any physical health problems that may affect his/her ability to engage in sexual activity?

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