MANAGING SEXUALLY INAPPROPRIATE BEHAVIORS IN NURSING HOME PATIENTS

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OUTLINE

• Basic Understanding of Sexuality in Nursing Homes
• Barriers to Sexual Expression
• Sexuality and Dementia
• Inappropriate Sexual Behaviors
• Approach to and Management of Inappropriate Sexual Behaviors
• Case Discussion
• Summary

SEXUALITY IN NURSING HOMES

• Fundamental Truths
  • We are all sexual beings from birth to death with a fundamental need for touch and sexual self-expression
  • Conditions in nursing homes and assisted living facilities may hamper the satisfaction of this need
  • Sexuality is generally a challenging issue for many healthcare workers; it is a sensitive, emotional, and “taboo” topic often shrouded in misinformation and fear

Katz, A. AJN. March 2013
SEXUALITY IN NURSING HOMES

- Sexual interest does not decrease in older adults residing in nursing homes although the focus on genital sex does; there are fewer opportunities for sexual activity and an increased need for non-coital activity such as hand-holding and kissing.
- All individuals living in long term care facilities have a new home where they are entitled to dignity, warmth, caring, and YES, even an active and satisfying sexual life……but, is this the reality?
- Sexuality and older adults is rarely discussed in an open and constructive manner…YES, many are sexually active!!!

Katz, A; AJN: March 2013
Higgins, A, et al; Br J of Nursing: 2004

SEXUALITY IN NURSING HOMES

- Studies done over the past 30 years have shown that 50-90% of people over 60 years of age were sexually active at least once a month and that regular sexual activity continues through the 7th and 8th decade.
- Factors influencing sexual behavior in the elderly:
  - Availability of a willing and able partner
  - Physical and mental health of the individual and partner
  - The availability of privacy
  - Past sexual history and practices


BARRIERS TO SEXUAL EXPRESSION

- Physical disabilities
- Adverse effects of prescribed medications
- Cognitive impairment
- Absence of opposite-sex partners (more women in LTC communities than men)
- Lack of privacy
- Attitudes of nursing staff and families (sexual expression is often considered “non-normal”)

Katz, A; AJN: March 2013
Higgins, A, et al; Br J of Nursing: 2004
BARRIERS TO SEXUAL EXPRESSION

- Examples of negative misconceptions about older people and sexuality
  - Sex is unimportant to older individuals
  - It is abnormal for older people to be interested in sex
  - Older people have no desire for intimacy
  - Older persons are not physically attractive and are not desirable
  - Sex is for the young and fit

Higgins, A; Br J of Nursing 2004

BARRIERS TO SEXUAL EXPRESSION

- Lack of policies in most facilities to help guide and support responses of staff members when sexual or romantic behavior is observed
- Organization’s relationship with a resident’s family members can directly influence the resident’s lifestyle.
  - One study found that any sexual activity in assisted living facilities was reported to family members who either gave consent for the relationship to continue or instructed the staff to put an end to it; families’ opinions outweighed residents’ wishes.

1. Katz, A; AJN, March 2013

BARRIERS TO SEXUAL EXPRESSION

- Possible staff responses to an older person initiating affection with another older person
  - Strong anger
  - Disgust and rejection of the perceived offender
  - Giving the person a “dressing down”
  - Moving the person to another part of the service or building
  - Ignoring the behavior

Mayer, KR; Sexuality and Disability 1998
SEXUALITY IN DEMENTIA

• Dementia is a progressive and deteriorating condition that affects the brain and consequently the memory, personality, and behavior.
• 2/3 of patients with dementia will have behavioral disturbances at any one point in time.
• 1/3 of patients with dementia and 4/5 of patients living in LTC facilities have behavioral disturbance

Higgins, et al; 2004

SEXUALITY IN DEMENTIA

• Just because an individual’s cognition declines does not necessarily imply that sexual intimacy and desires also decline or disappear.
• Oftentimes, sexual interest declines and sexual apathy ensues, but although rare, a disturbing behavioral outcome of dementia for some individuals is hypersexuality or inappropriate sexual expression.
• This is a significant challenge to caregivers and families and if not properly addressed has the potential to disrupt family and professional relationships because of its antisocial nature.

Higgins, et al; 2004

INAPPROPRIATE SEXUAL BEHAVIOR

• Hypersexuality or Inappropriate Sexual Behavior has no clear definition based on types or frequency of behavior and is often defined subjectively depending on the observer.
• Influenced by a host of factors including religious beliefs or prevailing societal views of elderly persons.
• Should be assessed as a part of the symptom cluster of behavior disturbances associated with dementia.

Higgins, et al; 2004
INAPPROPRIATE SEXUAL BEHAVIOR

• Literature reviews typically describe hypersexuality as behavior that involves inappropriate or uninhibited sexual behavior directed at oneself or another. Usually the behavior is directed to a number of individuals and not one specific relationship, but not “always.”
• Sexual disinhibition in patients with Alzheimer’s disease living in the community and LTC range from 2.9 – 8%
• A research study in 1995 found no statistically significant difference in increased or decreased sexual drive among 14 persons each with Alzheimer’s dementia or Pick’s disease.

INAPPROPRIATE SEXUAL BEHAVIOR

• Why does hypersexuality in dementia occur?
  • Disruption to the neural pathways related to the sex drive
  • Sexual manners are learned behaviors that might be forgotten in dementia
  • Psychological need for intimacy that has been unfortunately sexualized. Patients with dementia might feel disconnected from others with the loss of speech and the ability to communicate their desires.
  • Consequently, they act out on a strong need for human connection and touch as a result of “iatrogenic loneliness.” (attitudes and organizational structure that discourage or fail to accommodate any form of intimate expression or relationship within the institutional setting).

Higgins, et al 2014

INAPPROPRIATE SEXUAL BEHAVIOR

• Indications for treatment of Inappropriate Sexual behavior
  • Impairment of care delivery in a given environment
  • Persistent behaviors toward other patients or staff that are accompanied by aggression
  • Failure to respond to non-pharmacologic approaches to management
INAPPROPRIATE SEXUAL BEHAVIOR

- Patients with dementia might just crave the sensation of touch itself.
- They may confuse staff (along with other residents) with a much loved partner or misinterpret the interest of another resident and respond out of that misinterpretation.


INAPPROPRIATE SEXUAL BEHAVIOR

- Examples of Inappropriate Sexual Behavior
  - Touching the breasts, buttocks and genitals of staff and other residents
  - Kissing and hugging that exceed mere affection
  - Exposing genital areas (disrobing of self or others)
  - Making sexually suggestive remarks
  - Attempting intercourse and oral sex
  - Public masturbation
  - Requesting unnecessary genital care
  - Viewing pornography in public


APPROACH TO AND MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR

Dr. David Beck
APPROACH TO INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• Nursing homes are not sexy
• Many facilities have no formal policy regarding sex between residents

APPROACH TO INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• WHO: Sexuality is integral part of personality…and is a basic need
• Sex is always more than sex
• …continued involvement with life
• …validation of self-worth

APPROACH TO INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• American Association on Intellectual and Developmental Disabilities: “People with intellectual and/or developmental disabilities…have inherent sexual rights…”
MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR

- Nursing Homes may prohibit all sexual activity out of an abundance of caution
- Concern about falls
  - Falls are most common source of nursing home litigation
- Healthcare is second most regulated industry next to nuclear energy
  - Hill, 2014

APPROACH TO INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

- NH’s attempt to be like resident’s home.
- Denying sexuality is denying part of their humanity.
- Should be allowed as long as it is lawful and patients involved are able to consent.

LEGAL CONCERNS

What is consent?
How do you assess ability to consent?
Is an assessment of capacity necessary for that particular person?

Hand holding and self touching are NOT considered sexual.
LEGAL CONCERNS

Family members cannot consent.
Cannot give permission in DPOA document.
Homes can be civilly, but not criminally responsible.
“Reasonable caution or diligence”
“Duty to protect”
Reasonable concern about resident’s capacity to consent.
Residents should be able to engage in legal sexual expression.
Balance

LEGAL CONCERNS

Capacity to consent is presumed.
Compelling evidence is required to override that presumption.
Capacity is context specific.

LEGAL CONCERNS

A. How is capacity determined?
Capacity is both the ability to understand information regarding a decision and appreciate reasonably foreseeable consequences.
“Rationally evaluate”
Identify major risks
LEGAL CONCERNS

A lack of insight should not be confused with risky, uncommon, eccentric behavior. The right to voluntarily assume risks is to be respected.

LEGAL CONCERNS

Justification of choice
Chain of reasoning
Logical consistency
... Consistent with previous actions and values

LEGAL CONCERNS

B. What is capacity consent to Sexual Activity?
• 1. Criminal Code
  • 1. Basic understanding of sexual and nonsexual touching
  • 2. Ability to express personal choice
  • 3. Ability to resist coercion/exploitation
  • 4. Ability to recognize distress/refusal in partner and stop
  • 5. Ability to understand appropriate and inappropriate locations and times
LEGAL CONCERNS

- II. Jurisprudence
  - No case law
  - Capacity to marry may be useful
  - “Not a particularly rigorous test”

COGNITIVE CONCERNS

- III. Clinical Evaluations
  - Cognitive screening & extended interview
  - Focus on:
    1. Awareness of the relationship
    2. Ability to avoid exploitation
    3. Awareness of potential risks

COGNITIVE CONCERNS

- Awareness of the relationship
  1. Is the patient aware of who the other person is?
  2. Does patient believe the other is spouse?
  3. Is patient aware of who is initiating sexual contact
COGNITIVE CONCERNS

• When should assessments take place?
• Need more than just cognitive impairment.
• Staff may provide pre-sexual care, post-sexual care, assistive devices & information within professional boundaries

BEST PRACTICE

LTC facilities should have policies on sexual expression that are communicated to patients, families and DPOAs prior to admission. LTC facilities should conduct clinical evaluation of sexual consent shortly after admission. (???)

Patient must be found legally incapacitated prior to sexual expression being prevented.

BEST PRACTICE

Homes are to try to improve QOL
Involve substitute decision makers even though they do NOT have legal standings
OR Prevent all sexual conduct
BEST PRACTICE

Nursing home need to safeguard against staff preventing sexual expression based on their own value system.
Sexual expression is not necessarily a behavioral problem.
Staff should be directed where to ask questions.

BEST PRACTICE

• Bottom Line
  1. Legal Approach: No sexual activity if unable to consent
  2. Supportive/Assistive approach: Rely on substituted judgment

"Seeking advice or support for important decisions is something almost everyone does, regardless of their decision-making capacity."

BEST PRACTICE

Lack of legal analysis/direction.
There are basic human needs for human touch, closeness and intimacy.
There is also a need to do more than just insulate homes from legal liability.

Hayden, 2014
APPROACH TO INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

- History
- Physical
- Targeted Labs
- Collateral History

APPROACH TO INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

- Look for:
  - Mood disorder
  - Psychosis
  - Substance use disorder (EtoH, etc.)
  - Attention seeking behavior
  - Hypersexual personality traits
  - Potential precipitants or triggers

APPROACH TO INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

- Triggers
  - Meds (benzodiazepines, dopamine agonists, androgen supplement)
  - Motivation
    - i.e. forgot clothes
    - too warm
    - delirium
MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• Sequential approach
  • Start with non-pharmacological methods
    • Removal of precipitating factors
    • Distraction
    • Opportunities to relieve sexual urges
    • May need to move/separate people
  • Stop medications that may be contributing

MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• DISTRACTION
  • Crafts
  • Consistent Redirection
  • Enhanced communication through an interpreter

MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• PHARMACOLOGIC
  • All off-label
    • Antidepressants
      • SSRI’s (first line)
      • Sertraline
      • Mirtazapine
      • TCA’s
      • Trazodone
MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

- ANTIPSYCHOTICS
  - No trials focused specifically on sexual behavior
  - Benefits only modest
  - Haloperidol
  - Quetiapine
  - Aripiprazole
  - (after antidepressant + other antipsychotic)

- ANTIANDROGENS
  - After failure of antidepressant or antidepressant + antipsychotic
  - Medroxyprogesterone
  - Cyproterone
  - Finasteride

- HORMONAL AGENTS
  - Estrogens (decrease LH and FSH leads to decreased testosterone)
  - Leuprolide (GnRH analogue) Downregulates LH and FSH
MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• ANTICONVULSANTS
  • Gabapentin
  • Carbamazepine (may decrease testosterone)

MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• CHOLINESTERASE INHIBITORS
  • Conflicting results
    • Rivastigmine
    • Donepezil

MANAGEMENT OF INAPPROPRIATE SEXUAL BEHAVIOR IN PEOPLE WITH DEMENTIA

• MISCELLANEOUS TREATMENTS
  • Cimetidine
  • Beta Blockers
  • Pindolol
  • Propranolol
  • Ketoconazole
  • Spironolactone
CASE DISCUSSION

Two residents of a for-profit nursing home want to share a bed but can do so only with the cooperation of the staff. One is a 90 yr old man who is blind and a double amputee with well-controlled heart failure. The other is an 86 yr old woman with severe rheumatoid arthritis and a colostomy. Both have outlived spouses after long marriages and have been residents in the facility for some time; both have a normal mental status. The residents have had two falls when in her single room alone, and they have asked for staff assistance to undress and share a bed. Some staff members are uncomfortable and want the medical director to call the families to stop this behavior. Both residents say that they do not want their families informed. There is no relevant statement regarding the facility's protocols or limitations in the materials provided at admission.

CASE DISCUSSION

Which of the following is the best course of action?
A. Have a private conversation with the lead family member in each family.
B. Research civil rights laws to determine the legality of the couple’s request
C. Pursue a compromise, such as working only with volunteer staff or getting married, with the couple and the staff
D. Advise the couple that sexual activity is hazardous to their health and cannot be allowed.

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GRS, 7th Edition:2010
CASE DISCUSSION

87 y.o. male is resident of an assisted living facility. He has moderate dementia. His wife died unexpectedly 1.5 years prior to the observation of him sleeping in the bed with other female residents. There was no known or observed sexual aggression. He reportedly picked up one female resident from her wheelchair and put her in his bed. At that point, the director of nursing (DON) contacted the family and insisted on his discharge from the facility. Intervention: admit to inpatient geropsychiatry unit was suggested and accomplished. The DON contacted this provider and voiced that she would not accept him back in the facility unless he was started on Provera (medroxyprogesterone). What is your response to the DON?

My response:
"This patient will not be started on Provera due to possible development of hypercoagulability causing DVT, pulmonary embolus, and other potentially morbid or fatal complications. Let's wait and see what treatment is recommended by the inpatient team on the Geropsychiatry unit at the hospital."

Epilogue
The patient was readmitted to the facility and continued with the behaviors. He was placed on a waiting list at another AL facility to be admitted to an all male unit within the building.

CASE DISCUSSION

85 y.o. male admitted to the Dementia Care Unit of the nursing home. Within one month of admission, he is observed touching and squeezing the breasts of female patients on the unit. The behaviors did not change with redirection and verbal negative reinforcement by nursing staff. He was started on valproic acid and was less aggressive with touching and more often would ask, “Can I touch your breasts?” He started becoming more sedated and the valproic acid was tapered and discontinued. Only to be followed by a return of sexual aggression not only to female patients but to nursing staff as well. He was started on quetiapine at a low dose with no response. The dose was increased to less than 1 mg per 24 hours. He again became more sedated and withdrawn. He would not eat or drink, became dehydrated and was subsequently hospitalized. He did not return to the nursing home after hospitalization because he was admitted to a local inpatient hospice where he later expired.
SUMMARY

• Resident sexual expression covers a wide variety of activity from flirtation to sexual intercourse and is evident in nearly every LTC facility.
• Reactions to these activities by family and staff members, especially nursing staff, can be quite negative and interfere with residents’ quality of life.
• Nursing staff and families may require additional education on “sexuality and older adults” in order to create an environment in which healthy sexual self-expression is supported (examine your own attitudes toward sexuality in older adults and enable open discussion among staff about personal attitudes toward sexuality).

SUMMARY

• Establish guidelines for your facility outlining the rights of both residents and staff when questions about sexual expression arise.
• Caution is needed when evaluating inappropriate sexual behavior to ensure that the events have not been perceived incorrectly and that treatment is definitely warranted.
• An initial careful evaluation and nonpharmacologic treatment should precede attempts to treat behavior with medications.

SUMMARY

• No randomized controlled trials of treatments for dementia-related sexual behavior have been reported.
• We are left to rely on evidence from case reports and a few small studies (with level II or III evidence).
• When using pharmacologic treatment, one must keep in mind the drug’s toxicity profile, communicate the potential for benefits and harms to patients, families and caregivers, and carefully document these discussions.
QUESTIONS???

Photos Courtesy of KU Landon Center on Aging, K.C., KS