Gray Hair and Groping

The Complexities of Sexuality and Sexual Behaviour in Long-Term Care

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Disclaimer

No animals, children or seniors were harmed in the making of this presentation

However, two physicians were slightly embarrassed

Case #1

- 77 yo male referred by FMD
  - Increasing sexual preoccupation for years
    - Approaching young women in public
    - Increased requests for intimacy
    - Recently banned from Gardening Club
  - Past Forensic/Sexual Disorders assessment
    - Involved with a prostitute, purchased car and paid for her apartment
    - Wife recognized this was “not my husband” and worked through the distress

Case #1

- Signs of dementia present
  - repetitiveness, apathy, mild word-finding
- No evidence of other psychiatric disorder
  - depression ~10 ya after friend died from prostate Ca (has been worried since)
- Generally healthy
- Lab findings unremarkable

Case #1

- Pleasant and cheerful on interview
  - eager to please, prominent head-turning
  - noticeably impulsive in responses
  - MoCA 18/30 (executive decline especially)
- Social Background
  - classical British private school education
  - “very proper English Gentleman”
  - worked as accountant for 45 years
  - married 40 years, no children

Sexual Expression in the Elderly

- Various reactions to the topic
  - discomfort?
  - humor?
  - disgust?
  - concern?
- Uncomfortable topic to discuss
    - expectation of shock and offense
    - dealing with our own baggage

Sexual Expression in the Elderly

- Myths
  - Sex is only for the young
    - pervasive throughout society
    - Youth = Beauty = Sex
    - self-fulfilling prophecy
    - do we ask about sexuality?
      - fear of giving offense
      - our own discomfort and hang-ups
      - usually not explored until there is a problem…

Sexual Expression in the Elderly

- Myths
  - ~~Sex is only for the young~~
  - Not physiologically possible
    - hormonal changes affect performance/comfort
    - illness can affect functioning
    - not all sexual expression is physiologically demanding
    - discussion and reassurance can relieve anxiety and thus improve performance/enjoyment

Sexual Expression in the Elderly

- Myths
  - ~~Sex is only for the young~~
  - Not physiologically possible
  - Institutionalization is the end of sexual activity
    - often facilities cannot offer much privacy
    - often sexual activity is frowned upon/discouraged
    - lack of available partners

Normal Elder Sexuality

- Sexual interest in old age?
  - sexual interest at young age
- Performance changes, Desire doesn't
- Sexuality is more than intercourse
  - "any activity that leads to the sensation of feeling loved"
  - affection, romance, companionship, personal grooming, touch, feeling attractive, feeling masculine, feeling feminine
- Elderly rating importance of various aspects
  - social intimacy rates highest
  - intercourse quality rather than frequency
  - increased importance of non-intercourse expressions
- 75-80% of NH residents report sexual thoughts/fantasies
  - few are active because of barriers

Barriers to Sexual Expression

- Lack of privacy (physical and informational)
  - consultation in LTC for 85 year old man
  - living on higher functioning unit
  - wife in facility with very severe dementia
  - patient very attentive
    - visits daily, very loving, stays for meals
  - in evening returns to own unit
    - sexual relationship with female co-resident
  - staff on wife's floor very upset with him
  - staff on his floor angry with staff on her floor
  - staff on other floors have strong opinions

Barriers to Sexual Expression

- Lack of privacy (physical and informational)
- Lack of willing/able partner
  - LTC residents: 12% married, 70% women
  - at age 65: 1 male:3 female
  - 75% of men in LTC married, 35-50% of women
- Cohort attitudes
  - Victorian upbringing
  - younger elderly can have different viewpoint
- Staff attitudes
  - some consider pornography or private masturbation to be inappropriate

Barriers to Sexual Expression

- Family attitudes
- Medication side effects
- Feeling unattractive
- Physical limitations
- Mental Illness
  - dementia
  - depression
- Medical Illness
  - erectile dysfunction and dyspareunia

Senior Sexuality in Dementia

- Study: 47 couples with dementia patient
  - ¼ still sexually active
    - All caregivers felt satisfied and rated patient so
  - ¾ not sexually active
    - ⅓ unsatisfied, also felt partner unsatisfied
    - ⅔ satisfied and felt partner was as well
  - better executive function = more likely to be sexually active

Inappropriate Sexual Behavior

"…a vigorous sexual drive or other sexually related problems developing after the onset of dementia that interfere with normal activities of living or are pursued at inappropriate times and with unwilling partners"

Inappropriate Sexual Behavior

- Sexual Talk
- Sexual acts
  - disrobing
  - masturbation
  - touching
- Implied sexual acts
  - open use of pornography
  - requests for unnecessary genital care
- False allegations of sexual abuse
- Sexual activity with non-consenting partners

Inappropriate Sexual Behavior

- Some studies to examine prevalence
  - wide variation in frequency
    - 2-17% of dementia
    - large cross-sectional study of Community/LTC/IP
      - overall prevalence 1.8%
      - Men >>> Women (93% vs 7%)
      - Community = LTC = IP
      - all types of dementia (? more common in vascular)
    - Case series of 133 inpatient admissions
      - 15% had ISB
      - no difference based on type of dementia, sex (?!?), age, education, MMSE

Causes of ISB

- Physical
  - Medication effects
  - Medical Issues
    - frontal lobe lesions or septal injury or other TBI
    - Parkinson's Disease (+/- dopaminergic agents)
    - post-ictal period, or marked improvement in seizure control
    - mania, MS, stroke
  - Libido regulation (temporal/frontal damage)
    - disinhibition
    - loss of learned sexual manners
- Intellectual
  - Forgetting recent sexual activity
  - Misidentification of partner
  - Misinterpretation of care

Causes of ISB

- Emotional
  - Previous behaviors
  - Psychological causes
    - boosting declining self esteem and self-image
    - demonstrating control
  - Loss of closeness and contact in LTC
  - Boredom, self-stimulation
- Capabilities
  - Unaware of behavior
    - Public vs Private behaviors
- Environmental
  - Privacy for appropriate behaviors?
- Social
  - Misinterpretation by observer

Case #1 – The Gregarious Gardener

- 77 yo English Gentleman with ISB
  - Review of medication
    - taking multiple OTC supplements
    - “Prostate Health Supplement”
      - worried about getting Prostate Ca like friend
      - contains androgen-like compounds
  - All ISB stopped within one week of D/C
    - single recurrence in 1½ years
      - hairdresser leaning over his face…

Case #2

- 88 yo man in LTC, referred to outreach for ISB
  - Moderate-severe dementia, physically healthy
    - expressive aphasia, mild executive dysfunction
  - Repeatedly rubbing genitals in public
    - accepts redirection well when told to stop
    - no inappropriate comments, no touching
    - no aggression to staff or residents
  - Minimal change otherwise
    - increase in incontinence attributed to dementia
    - some nursing notes indicate episodes of confusion

Case #2 – The Recurrent Rubber

- Urine dip showed evidence of UTI
  - treatment with Antibiotics cured his ISB

- Other possible explanations
  - genital rash?
  - clothing discomfort?
  - nothing else to do with his hands?

Is It Really ISB?

- Look for other explanations
  - Physical
    - grabbing genitals because of UTI?
    - rubbing because of rash?
  - Intellectual
    - appropriate behavior, inappropriate place?
    - lack of awareness
  - Emotional
    - expression of need for non-sexual intimacy?
  - Capabilities
    - unable to figure out clothing?
  - Sexual motivation?
    - random touching, compulsive handling

Case #3

- 75 yo lady in LTC
  - Sitting in lunch area finishing meal
  - Dr. Thomas approaches and asks how her lunch was…

  “Good... would have been better if I could have eaten it off of you…”

Case #3a

- 75 yo **man** in LTC
  - Sitting in lunch area finishing meal
  - **Young female doctor** approaches and asks how **his** lunch was…

"Good... would have been better if I could have eaten it off of you…"

Staff Preconceptions

- Gender biases
  - More female nurses
    - more likely to be targeted by male patients
  - Different perception based on gender
    - Female resident and male staff
    - Male resident and female staff
    - Female resident and female staff
    - Male resident and male staff

Case #4

- 68 yo man in religious commune
  - Retired pastor, lived in community >40 yrs
  - Early stage FTD complicated by depression
  - Sexual preoccupation and disinhibition
    - Approaching younger women
    - Inappropriate comments
    - Some excessive platonic touching
  - Community is horrified
    - But wants to be supportive

Case #4

- 68 yo man in religious commune
  - Treatment with antidepressant
    - Improvement in depression
    - Reduction in disinhibited behavior
  - Patient moved to male-only house
    - Additional activities and counselling help
    - Addition of a pet cat provides some companionship

Case #4

- 68 yo man in religious commune
  - Outreach RN receives urgent call
  - “You need to start hormone therapy because there have been two more incidents”
  - Two episodes of “ISB”?
    - Touched upper arm of younger woman and stated: “May the strength of the lord be with you”

Staff Preconceptions

- The Myths of Senior Sexuality
  - Any sexual expression = ISB
  - I'm uncomfortable → You're inappropriate
- Individual attitudes to sexuality
  - Avoidance of topic
  - Discomfort addressing issues directly
- Labelling as "Problem Patient"
  - Based on a few incidents → recall bias
  - Dangers of "word of mouth"

Assessment of ISB

- History
  - New behavior vs Exacerbation?
  - ABCs
    - Antecedents: what happens before the behavior?
    - Behavior: what is the patient ACTUALLY doing?
      - Be careful of interpretations of motivation and intent
    - Consequences: what happens because of the behavior?
  - Detailed tracking of behaviors
    - Help recognize patterns, settings, triggers, etc
    - Helps plan and target interventions

Assessment of ISB

- Physical
  - Physical and Neurological exam
  - Check for UTI
  - Review of medications
    - Anticholinergic medications, benzodiazepines
    - Anything new or changed?
  - Check for UTI
  - Rule out delirium or other treatable causes
    - Routine bloodwork
    - Check for UTI
- Intellectual
  - Are they going to respond to boundaries/redirection?
  - Can they express sexual needs?

Assessment of ISB

- Intellectual
  - Are they going to respond to boundaries/redirection?
  - Can they express sexual needs?
- Emotional
  - Changes in family dynamic?
    - Loss of spouse, less frequent family visits
  - Nature of previous relationships
  - Other sources of emotional distress
    - Is the patient reaching out for closeness?

Assessment of ISB

- Capabilities
  - Is this really an inability to manage ADLs
  - Are they still capable of self-gratification?
- Environment
  - Is there adequate privacy for appropriate activities?
  - Is something in the environment causing stimulation?
- Social
  - Previous sexual/relationship history
  - Previous behaviors
  - Look at our own preconceptions of the behaviors and sexuality

Management

- Be aware of the risk
  - It happens to many, no-one is immune

Management

- Be aware of the risk
- Be aware of what you are doing
  - Caution in draping to maintain privacy
  - Limit potential misunderstood touching
  - Don’t be shy about appropriate contact
  - Professionalism is a powerful tool

Management

- Be aware of the risk
- Be aware of what you are doing
- Maintain a professional relationship
  - Avoid suggestive actions/comments
  - Be aware of personal boundaries

Management

- Be aware of the risk
- Be aware of what you are doing
- Maintain a professional relationship
- Be aware of warning signs
  - Questions about marital status
  - Jokes about “getting together sometime”

Management

- Be aware of the risk
- Be aware of what you are doing
- Maintain a professional relationship
- Be aware of warning signs
- Focus on the actions, not the person
  - Be aware of your own feelings
  - Set firm but caring boundaries
  - Scolding usually elicits defensiveness

Management

- Be aware of the risk
- Be aware of what you are doing
- Maintain a professional relationship
- Be aware of warning signs
- Focus on the actions, not the person
- Respond to the problem, don’t ignore it
  - Physical: remove the hand or move yourself
  - Verbal: calm and measured responses

Management

- Be aware of the risk
- Be aware of what you are doing
- Maintain a professional relationship
- Be aware of warning signs
- Focus on the actions, not the person
- Respond to the problem, don’t ignore it
- Set limits and consequences
  - “If you keep touching me like that, I will have to get someone else to finish helping you dress”

Management

- Be aware of the risk
- Be aware of what you are doing
- Maintain a professional relationship
- Be aware of warning signs
- Focus on the actions, not the person
- Respond to the problem, don’t ignore it
- Set limits and consequences
- Acknowledge how you feel
  - Normal responses: anger, shame, disgust, fear…
  - Seek support in managing them – don’t avoid

Management

- Be aware of the risk
- Be aware of what you are doing
- Maintain a professional relationship
- Be aware of warning signs
- Focus on the actions, not the person
- Respond to the problem, don’t ignore it
- Set limits and consequences
- Acknowledge how you feel
- Education
  - Use resources to understand the problem better

Management

- Clothing that opens in the back
  - prevent fondling/masturbation
- Manual activities
  - folding towels, puzzles, busy boxes
- Educating caregivers to prevent avoidance
- Redirection with other basic needs
  - food, drink, conversation
- Distraction with other activities or objects
  - walking, exercise, stuffed animals
- Affection from family and pets

Management

- Understand own feelings about sex and seniors
- Remember that sexuality is normal
- Open discussion with family
- Redirection to private location (Do Not Disturb)
- ABCs
- Look for other explanations
  - Do you need to use the washroom?
- Think about consent when two people involved
- Who is this a problem for?
- Avoid labelling

Ethical Considerations

- Recent case
  - 76 yo female, recently widowed from 2nd marriage. Mild dementia
  - 79 yo male, wheelchair bound due to failed THR, wife of 50 yrs died from multiple strokes
  - Developed close friendship over many months, affection developed
  - Male approached residence requesting shared accommodation b/c want to be intimate

Ethical Considerations

- Lack of privacy
  - physical and informational
- Discouragement from staff (infantalization)
- Other interventions
  - condoms, lubricant, Viagra, toys, treatment for ED/dyspareunia
- Informed consent
  - personal health, partner health
- Changes in behavior
  - due to dementia or due to aging?

Ethical Considerations

- What to tell family?
  - how much involvement in decision?
- Screening for STDs?
- Handling claims of nonconsensual sex
- How much staff assistance?
  - inflating prosthesis? physical transfers?

Pharmacological Management

- Poor evidence for use of medications
  - Often used first line without behavioral interventions

Pharmacological Management

- Serotonergics
- Antipsychotic medications (prolactin)
- Antiandrogens
- Trazodone
- Estrogens
- GnRH Analogues
- Cholinesterase Inhibitors
- Gabapentin
- Other: buspirone, cimetidine
  - +/- ketoconazole, spironolactone

Summary

“When you have seen one case….

Summary

“When you have seen one case….

…you have only seen *one* case.”