SEX AFTER 60: NO WAY!

Neither pathological nor acting out behaviour

Research findings:
24% ?serious problems (exposure of genitalia, masturbation)
Horrification of acts significant
Staffs' attitudes and beliefs
- Discomfort in face of sexual behaviour, advances
- Uncertain as to what to do or say
- Response usually - do nothing
- Behaviours considered most taboo: Those that bother the resident vs those that bother others (masturbation occurs openly because of dysinhibition of dementia)
- Mobilizes paternalistic tendencies of staff
- If living with a dementia - apparent conviction cannot really consent
- Less than perfectly retained social discretion
- Jealousy on part of observer
- Repugnance - less cognitively impaired (P) pursuing a more cognitively impaired (V)
- Someone else's moral values, moral compass
- Use of shame or guilt
- Level of comfort with gay/lesbian relationships

SEXUALITY Vs INTIMACY

Sexuality

Encompasses all feelings, attitudes, and behaviours that contribute to a person's own sense of womanhood or manhood (Ekland & McBride, 1997)
Highly subjective: close companionship, touch and be touched, associated with body language, sexual activity and intercourse (Deacon et al, 1995)
Self-concept and coping style (imp. Past, present)
25% men over 80 and majority of women in 70s regularly have intercourse
Note: Have capacity for sexual pleasure even when diagnosed with a dementia

Intimacy

Need and ability to experience emotional closeness with another human being and to have that closeness predictably reciprocated (Dalley, Dennis)
Need to be touched, feel warmth, to share
Search for comfort and closeness

Dr. Lois Stewart-Archer, RN, CPMHN(C)
Regional Clinical Nurse Specialist, WRHA Geriatric Mental Health

CONSENTING ADULTS

Those in LTC may exhibit these types of sexual activity

- **Consensual**

- **Willfully indiscreet**
  Inoffensive, generally acceptable
  Overly friendly hug, kisses, off-colour jokes
  Understood in context of dementia

- **Sexually Explicit**
  Dysinhibited/Sexual harassment
  Behaviour may be deliberate or reaction to trigger
  May appear deliberate due to intensity and circumstances
  Often found distasteful by family and care providers
  Urinating/masturbating in public

- **Room Hopping**
  Misinterpretation of cues as propositioning
  Resident entering another's room and lying in or on bed
  Searching for place to lie down or companionship whilst resting

Resident/Resident Abuse

Staff recognizes responsibility to protect from abuse, however unsure how to define boundaries in less clear situations

Those who are capable of consensual sex will display the following

- **Ability to identify desired partner** (Do they believe it's their spouse?)
- **Awareness of relationship** (Are they aware of the other's intent?)
- **Ability to express the degree of intimacy desired**
- **Avoid exploitation** (coercion)
- **Sexual history usually consistent with present behaviour**
- **Awareness of potential risks** (e.g. STDs)

Responsibility of LTC/PCH

The standard: If two consenting, cognitively intact, unmarried then taboo lessened.
However, role is **not** that of parents, nor to control behaviour.
Need a policy for consistency and direction

Determine competence to: understand, consent, and form relationship
If competent, alternative decision-maker/family not to be involved unless Client requests
Support client's autonomous decision
Not simply protect
Assess whether attention forced or coerced
Offer support, privacy, and understanding
Assess impact of relationship (self-esteem, well-being)

Families' Impression/Views

- Describe client's values
- Discuss concepts of self - 'then self' vs 'now self' impacted by dementia
- 'Now self' - acting in present time, not needing to be in context with long held values.
- Ethicist: discontinuity of personal identity - refuted scientifically, morally, and metaphysically (Post, 2001)
- Mental clarity during intimacy
- Loss of self-esteem due to contravening long-held values
- Integrated rather than separated by gender
- Normalization of relationships
- Integrated activities chance for socially acceptable communication, warmth, touching

Educate staff:

Understand client's sexual needs and feelings
Assist to manage more appropriate behaviour
Non-intercourse sexual contact - oral sex, close intimate body contact; behaviours considered OK
Perceptions shape responses
Relationships between staff/resident influence response

- Is the action sexually motivated?
- Is the action consistent with past sexual patterns?
- Is there a trigger for the sexual response?

Community partners special needs:

Allow time, space for intimate contact as needed
Healthy partner's frustrations/feelings of guilt; may need counseling – address
Provide discussion groups and sexual education for all involved – new info. STDs
Be supportive of sexual functioning as of other aspects of personhood
Quality of life – Take steps to improve and support in a mature reaching out
Consider sense of self as a loving feeling, person