Intimacy, Sexuality & Dementia

Guidelines for Dementia Care Settings

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OBJECTIVES

• Define sexuality and intimacy and its role in “personhood” throughout life
• Understand the effects of dementia on sexuality and intimacy
• Recognize the impact of staff’s attitude and values concerning sexuality and later life
• Learn to utilize behavioral interventions to modify inappropriate sexual behavior
Test Your Knowledge

True or False

1. The need for intimate relationships diminishes with age.
2. The most common reason elderly women are not sexually active is the lack of opportunity.
3. Aging brings on a loss of interest in sex.
4. Sexuality does not affect an elderly person’s self-esteem.
5. The DOH has stated that “Sexual expression is a part of quality of life and a resident right.”
Excerpts from March 2002 DOH Letter to Administrators:

Estimate: “90% of nursing home residents are cognitively impaired, and 67% to 78% have a clinical diagnosis of dementia”

“Admission to a nursing home and a diagnosis of dementia does not necessarily curtail residents’ needs to seek the comfort of sexual expression, nor should it.”

“Sexual expression is a part of quality of life and a resident right.”

alzheimer’s association™
“I know I love him”

“I just don’t know who the hell he is.”
INTIMACY AND SEXUALITY DEFINED:

**INTIMACY**- Affection, respect and friendship marked by close acquaintance, association, or familiarity; Private & personal; friendly, promoting close personal relations (sexual or otherwise) varies from relationship to relationship, can be physical/emotional/spiritual in nature.

**SEXUALITY**- Experiencing & expressing oneself as a sexual being, behaviors, actions, sexual contact, actions, biological, erotic dimension
The Effects of Dementia on Intimacy & Sexuality

- Change in ability to care for self (ADL’s)
- Change in social interactions
- Cognitive, behavioral & emotional changes
- Physical changes
- Medications interfering w/ physical/sexual functioning
- Caregiver role changes
- Side effects of medication
Facts about Alzheimer’s & Sexual Behavior

- Not all residents have or will display sexual behaviors
- Damage occurs in the center of the brain that controls sexual impulses
- The resident may believe you or another resident are their spouse
- The sexual behavior can be upsetting to others
INAPPROPRIATE BEHAVIORS

LOSS OF INHIBITIONS:
- Undressing in public
- Fondling of genitals in public
- Touching, kissing, fondling strangers
- Public urination etc.
- Public masturbation or handling of genitals
- Suggestive behavior
- Sexually laden language
Inappropriate Behaviors (Cont.)

- Heightened interest in sex
- Misinterpreting affection (or platonic touch) as a sexual overture
- Unwarranted jealousy, suspicion
- Not recognizing partner
  - Flirting or unwanted sexual advances toward others
  - Making sexual remarks or being sexually aggressive
  - Mistaking paid caregiver for spouse or partner
  - Exposing oneself during personal care tasks
Causes of Inappropriate Sexual Behavior

Internal Causes
- Sense of threat or fear
- Loss of control
- Frustration with tasks
- Fatigue
- Impaired perception
- Pain
- Medication effects
- Misinterpretation of behavior

External Causes
- Physical environment
- Interpersonal approaches by staff or other residents
- Environmental stimulation
- Use of chemical/physical restraints
Appropriate Responses to Sexuality

- All staff should learn about the patient & the history of past behavior and social relationships
- Always try to **preserve** and **respect** remaining capabilities
- People with dementia continue to need loving, safe relationships and caring touch…
- Important to remember that what we call “inappropriate” behaviors are often private acts in public places
Forgetting Social Etiquette

An unfortunate part of the brain damage that occurs with Alzheimer's can be the loss of learned social manners and rules.
Positive Interventions:

- REMAIN PATIENT & CALM
- GENTLY LEAD THEM TO A PRIVATE PLACE.
- WHEN THE GOING GETS TOUCHY- TRY REDIRECTION OR DISTRACTION
- GIVE AFFECTION AS MUCH AS POSSIBLE
- MONITOR YOUR OWN BEHAVIOR
  (EX: TOUCHING, OR UNDRESSING IN FRONT OF PWD BEING MISINTERPRETED)
- GIVE ATTENTION & REASSURANCE
- IDENTIFY YOURSELF TO REMIND PERSON OF YOUR TRUE RELATIONSHIP
- PROVIDE CLOTHING THAT MAKES EXPOSURE DIFFICULT *
- GET SUPPORT FROM SUPERVISOR, CO-WORKERS
- TURN THE SITUATION INTO ONE YOU CAN LAUGH ABOUT
**TIPS**

Dignified ways of accomplishing goals:

1. Redirect the resident/divert attention
2. Keep the resident occupied
3. Change clothing from dresses to pants, from pants with zippers to pants that pull up, wear clothing that buttons or zips in the back
4. Recognize fondling of genitals may feel good
5. Use a gentle “no” to interrupt the behavior
6. Use appropriate touch – hand shakes, patting, holding hands, hugging (be aware of this as it depends upon the resident. Let them initiate the contact)
7. Maintain eye contact
8. Do not get angry or laugh = even though *you* may be embarrassed. The behavior is due to disease.
Think about these possibilities:

• Relocation to a busy place or a quiet place
• A lapboard or pillow placed on lap/between the legs
• Suspenders to complicate pulling pants, underwear or incontinence products off
• A plastic cup athletic supporter
• A fanny pack worn in the front (items to fondle)
• A bracelet of small bells that may ring (distraction)
• Clothing modifications (loose or back openings)
• Monitoring antecedents of self-stimulation
WHAT NOT TO DO:

• Trying to "teach" the person with Alzheimer's that his behavior is "wrong"
• Belittling, scolding, making fun of the person
• Threaten or attempt to punish the person
• Argue or try to convince
• Be judgmental or confrontational
• Reprimanding or being punitive
• Isolation or refusing to provide services
• Chemical Restraint
Can you think of reasons for these behaviors that aren’t sexual?

- Sally came outside to find Joe sitting on the porch in plain view of the street with nothing on except his hat.

- Fred noticed that Ann was constantly unbuttoning her blouse.

- Jane saw that Allan often unzipped his pants.
Can be based on religious/personal/cultural beliefs

MYTHS & FACTS
**MYTHS & FACTS**

MYTH: Sexual desire diminishes with age or is abnormal for seniors

**FACT:** Desire is natural & life long

MYTH: Dementia brings about heightened sex drive

**FACT:** Often there is a decrease but not necessarily

MYTH: **ALL** inappropriate behavior is sexual in nature

**FACT:** Behavior can be triggered by - Environment, Emotion, Physical factors, Loss of social skills

MYTH: Medical conditions are the end of a sex life

**FACT:** Modifications may be needed, but it is not an end to a sex life
MYTH: ALL Seniors are Heterosexual

FACT: Sexuality was repressed for generations. AD impacts impulse center. People may reveal sexual preferences that never showed before.

MYTH: Seniors do not masturbate.

FACT: Masturbation is a normal, healthy, sexual release or a sexual pleasure

MYTH: Undoing clothing or disrobing in public is always a sexual gesture

FACT: There are usually unrelated reasons to cause someone w/ dementia to partially or completely disrobe
Human Needs

Connection to others, vs Loneliness

Safety vs. Unpredictability

Self Esteem & Recognition vs Lack of Fulfillment

Intimacy & Sexual gratification vs Lack of Sexual Expression

Acceptance vs Isolation

Meaning vs Emptiness

Affection vs Physical Distance
MIRROR, MIRROR ON THE WALL...
ASK YOURSELF...

- What do **YOU** think about sexuality?

- What are **YOUR** thoughts about relationships, love, human contact, resident intimacy, resident sexuality?

- What are **YOUR** beliefs about sex and age?

- What is **YOUR** comfort level regarding sex – Do you nervously giggle/make jokes/feel squeamish?

- What is **YOUR** reaction to the terms masturbation, heterosexual, homosexual, bi-sexual, abstinence, love?
AND ASK YOURSELF...

- Does your behavior appear to be flirting?
- Is your good-natured teasing suggestive without meaning to be?
  - (Ex: Calling the patient a “dirty old man”)
  - “Hey handsome, how’s my boyfriend/my man?”
- Are your comments being misinterpreted? How might they be?
What kind of professional caregiver are you?

★ How positive are you in your day-to-day communication?
★ Do you touch the person? How?
★ Do you make eye contact? Do you maintain eye contact?
★ Is your stance one that suggests comforting, caring, intimacy? (Intimacy does not necessarily mean sex.)
★ Do you give the resident your attention?
★ Are your gestures easy, relaxed, non-threatening?
★ Do you show respect & treat the person like an adult?
ALZHEIMER’S ASSOCIATION

3 Step Problem Solving approach to difficult behaviors

1. Identify and examine the behavior
   √ What was the behavior?
   √ Is it harmful to the individual or others?
   √ What happened before the behavior occurred?
   √ Did something spark the behavior?
   √ Is the resident depressed or angry?
   √ What happened immediately after the behavior occurred?
   √ How did you react?
   √ Consult a physician to identify any causes related to medications or illness.
2. Explore potential solutions

√ What are the needs of the person with dementia? Are they being met?
√ Can adapting the surroundings comfort the person? Can you lower the noise level or turn on lights?
√ How can you change your reaction or your approach to the behavior?
√ Are you responding in a calm and supportive way?
√ Do you display an attitude or make fun of the person with the behavior?

3. Try different responses

√ Did your new response help?
√ Do you need to explore other potential causes and solutions? If so, what can you do differently?
SUMMARY

- Difference between Intimacy & sexuality
- Myths & Facts about aging
- Understanding that we all have Basic Needs
- Behavior – understanding the types of behaviors and how, as professional caregivers, you may contribute to the behavior
- Ways to provide assistance