Sexual Behaviors in dementia residents is not uncommon. NH residents are not asexual and sexual behavior is a natural part of being human, regardless of age. These behaviors can be very uncomfortable to deal with for staff due to the different views that each individual may have about such behavior. In my opinion, we must try to set aside our own judgements about sex and assess sexual behaviors on a case-by-case basis for each patient. Education of staff may need to be the first priority in order to address sexual behaviors in dementia and there are links to educational resources in the outline below.

Sexual behaviors in patients with dementia may be related to disinhibition or a loss of the ability to recognize societal norms and filter behavior and thoughts in the same manner as someone without dementia. We can see similar behaviors in other pathologies involving brain trauma, stroke, multiple sclerosis, and neurodegenerative disorders such as Huntington's disease. The loss of a "filter" can lead to many of the behaviors that we see in dementia in addition sexual behaviors. We typically try to address these behaviors by finding and addressing an unmet need that may be triggering the behaviors. Sexual behaviors can be addressed in the same way but may require more creative solutions.

Frontotemporal dementia (FTD) often involves behavioral changes before memory loss and can present with hypersexual behaviors. FTD often presents with abnormal behaviors, but these patients may initially have no significant memory deficits. Sexual behaviors in FTD seem to be more prominent and may involve not just disinhibition but also an increased desire for sex (7).

As with all dementia behaviors, non-pharmacologic treatments are the mainstay of therapy. Attempting to find an unmet need and addressing that need should be the first approach.

With sexual behaviors, this must involve recognition of the fact that sexual behaviors are a primal component of the human brain. When a disease state removes the filter that often suppresses these urges, they surface. Attempting to address the urges may involve creative solutions like dolls, toys, or redirection techniques. A search for potentially stimulating triggers should be performed and attempts to remove, or address, those triggers may be helpful. It is not uncommon for a dementia patient to perceive a sexual stimulus from something that we might not normally consider sexual.

Pharmacologic therapy is sometimes necessary but there is no consistent data to guide the use of medications to reduce these sexual behaviors in dementia (2). Almost all drug classes have been used to attempt to reduce these behaviors with varying levels of success. SSRIs are safe first line agents but even among this class there may be agents that are useful for one person but not for another. Antipsychotics are likewise often used with variable efficacy and these agents pose significant risks. Beta blockers, anti-epileptics, acetylcholinesterase inhibitors, cimetidine, finasteride, naltrexone and other drugs have been used with no consistent results. Hormonal agents, such as medroxyprogesterone, have also been used with some success but a careful evaluation of the risk/benefit profile should be performed. Use of hormonal agents is controversial and some view it as a form of “chemical castration.”

— Dr. David Shepherd

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# The basics

- Elderly are not asexual.
- Estimated prevalence of sexually disinhibited behavior and dementia 2 to 17% (8)
    - Equal frequency in men and women

    - Increases with increasing severity of dementia
- Dementia can cause apathy, decreased sexual interest and/or disinhibition and inappropriate sexual behaviors (1).
- Perceptions of sexual behaviors vary and can be influenced by:
    - religious views
    - societal views
    - personal views
    - ethical views
    - legal views
- Non pharm treatments should be tried first (Be creative)
- There are no definitive studies identifying an effective medication for dementia related sexual behaviors.
- Disinhibition may be the primary issue.
- Fronto-temporal dementia often presents with increased sexual behaviors. (7).

> # Why does sexual behaviour increase in dementia?
>
> ***Disease-related factors***
>
> 1. Sexual disinhibition is a recognised feature of frontal lobe lesions (Reference LishmanLishman, 1998) and forms part of Kluver–Bucy syndrome, originally described following bilateral temporal lobectomy in monkeys (Reference Kluver and BucyKluver & Bucy, 1937)
> 2. Disinhibition due to organic brain disease (especially frontotemporal dementias)

3. Normal etiquette may be forgotten
4. Delusions, hallucinations, misidentifications
5. Sensory impairments

***Social factors in inappropriate sexual behaviour***

1. Lack of usual sexual partner(s)
2. Lack of privacy
3. Understimulating environment
4. Misinterpretation of cues such as those seen on television or in opposite-gender carers
5. Unfamiliar environments

***Psychological factors***

1. Premorbid patterns of sexual activity and interest exercise a strong effect which continues after the development of dementia
2. Changes in mood state are commonly seen in dementia. Both depression and mania will affect sexual interest

***Drugs***

1. Alcohol and benzodiazepines can produce behavioural and sexual disinhibition in both healthy people and those with dementias
2. l-dopa can cause hypersexuality in people with Parkinson's disease

*Hypersexuality in dementia | Advances in Psychiatric Treatment | Cambridge Core*

# Assessment of inappropriate sexual behavior

**Rule out medical and psychiatric causes**

- mood disorder
- psychosis
- substance use disorder.
- attention -seeking
- benzos
- dopamine agonists
- androgen supplementation

Environmental or emotional triggers?

St Andrews Sexual Behavior Scale – SASBA-scale-and-recording-sheet.pdf (stah.org)

**Assessment of Inappropriate sexual behavior** (8)

- What form does the behavior take?
- In what context?
- How frequent is it?
- What factors contribute?
- Is it a problem? For whom?
- What are the risks involved? To whom?
- Are the participants competent?

> ***Investigative guidelines for resident intimacy and sexual behavior***

> ***This investigative tool was designed for the Health Facilities Division surveyors and investigators to assist them in the completion of comprehensive investigations of issues related to resident sexual behavior. It is not intended that each item included here be completed for each investigation, but the tool will serve as a checklist to ensure that all relevant information is collected. It will also be used to train new staff in the investigation of these issues.***
> *Intimacy Guidelines for LTC (ltcombudsman.org)*

# Assess capacity to engage in sexual relationships.

**Patient's awareness of the relationship** (8)

- Is the patient aware of who is initiating sexual contact?
- Is delusion or misidentification affecting the patient's choice (eg, is the patient mistaking the other person for his or her spouse)?
- Can the patient state what level of sexual intimacy he or she would be comfortable with?
- Can the patient avoid exploitation?
- Is the behaviour consistent with previously held beliefs and values?
- Does the patient have the capacity to say no to uninvited sexual contact?
- Is the patient aware of potential risks?
- Does the patient realize that the relationship might be time-limited (eg, if a placement is temporary)?
- Can the patient describe how he or she will react when or if the relationship ends?

Sexual Intimacy Capacity for Consent Assessment

American Medical Directors Association Policy and Procedure on Resident Sexual Expression and Intimacy

# Education of staff

**QUICK FAQ sheet** –

HF_Frequently-Asked-Questions-and-Answers-Related-To-Resident-Sexual-ActivityDownload

> ***A scoping review of education and training resources supporting care home staff in facilitating residents' sexuality, intimacy and relational needs – PMC (nih.gov)***
>
> ***The findings suggest that education interventions can improve knowledge and/or change care staff attitudes, in the short-term, towards older people's sexuality, intimacy and relational needs in care home settings, which can lead to facilitating staff to enhance person-centered care in this area of need.***
>
> ***The focus of the education interventions and resources was to increase knowledge and improve and/or change attitudes towards the:***
>
> ***(i) sexual expression of older people living in residential aged care,***
>
> ***(ii) sexuality and ageing and***
>
> ***(iii) expression of sexuality in people with dementia.***

Sexuality in Nursing Homes Education Module -Kansas State University, Center on Aging

Challenging Behaviors in Dementia Care (Streaming) – Positive Approach to Care – Shop

(teepasnow.com)

# Non-Pharmacologic Interventions

- Discontinue medications that worsen disinhibition.
    - Benzos, dopamine agonists
- Identify and remove triggering factors.
    - Consider ALL triggers. The trigger is sometimes not something that we would normally consider sexual.
- Distraction strategies
- Consider providing opportunities to relieve sexual urges (dolls, toys, consensual contact)

# Pharmacologic Treatments

- Currently there is little high-quality evidence to guide pharmacologic treatment.
- No randomized controlled trials. Evidence is based on case reports.
- SSRIs are probably the safest initial approach. You may need to try several SSRIs before moving on to another class of drug.

# Management Approach

- Start with Non-pharmacologic strategies (8)
    - Define target behaviors
    - Rule out delirium
    - Consider mood disorder (depression, mania) or psychosis
    - Review environmental factors
    - Review cognitive and sensory factors

    - Educate and support caregivers
    - Consider specific behavioral methods
    - Involve other interested parties if necessary
- Reduce or stop any meds that may disinhibit behaviors such as benzodiazepines, dopamine agonists, anticholinergics, etc…
- Select a target symptoms/behavior and a timeline to assess efficacy of any approach to curb the behavior.
- Measure the efficacy of the approach
- Revise the strategy
- Consider pharmacologic treatments in extreme cases
- Document your efforts
- Repeat and keep trying.

# References:


1. Approach to inappropriate sexual behaviour in people with dementia – PMC (nih.gov)
2. Treatment of Inappropriate Sexual Behavior in Dementia – PMC (nih.gov)
3. Extreme sexual behavior in dementia as a specific manifestation of disinhibition – PubMed (nih.gov)
4. Treatment and Management of Sexual Disinhibition in Elderly Patients With Neurocognitive Disorders – PMC (nih.gov)
5. Hypersexuality in dementia | Advances in Psychiatric Treatment | Cambridge Core
6. Sexual Aggression between Residents in Nursing Homes-Literaure Synthesis for an Undercatagorized Issue
7. Hypersexual Behavior in Frontotemporal Dementia: A Comparison with Early-Onset Alzheimer’s Disease
8. Hypersexuality in dementia | Advances in Psychiatric Treatment | Cambridge Core