Dementia is one of the leading causes of morbidity in the old age population. It is manifested in myriad forms including cognitive deterioration, behavioural symptoms, personality changes, and psychotic symptoms. This is further compounded by physical morbidities and social difficulties encountered in this age group. That makes the assessment of dementia essentially a multidisciplinary one. One of the behavioural symptoms encountered in dementia is inappropriate sexual behaviour (ISB). Although not so common, it is one of the most difficult behavioural aspects to assess and manage, which causes a great deal of distress particularly in carers, family members, nursing staff and other patients.

**Ageing, dementia and sexuality**

- Sexuality goes beyond the act of sexual performance. Sexual performance does decline with age due to many reasons; sexual satisfaction does not. Dementia may cause sexuality to be expressed in an inappropriate or socially unacceptable manner.
- The issue of sexuality in patients with dementia not only affects the patients themselves, but also their carers, particularly their spouses.
- A significant number of patients with dementia live in long term care institutions, so knowledge, attitude and values of staff have a significant influence on how sexuality is expressed.

**The problem and its magnitude**

- Three types of ISB are commonly identified – sexual talks, sexual acts and implied sexual acts.
- Prevalence of ISB in dementia population ranges from 2–25%. Given the increasing population of patients with dementia in UK, the absolute number of dementia patients exhibiting ISB is huge.
- ISB affects patients, their carers and medical staff. It also poses significant risk to patients themselves and other vulnerable people.

**Aetiology and assessment of ISB in dementia**

- Frontal lobe dysfunction may precipitate disinhibition, temporal lobe-limbic dysfunction may lead to hypersexuality, lesion in cortico-striatal circuits may cause ISB which is obsessive-compulsive in nature and hypothalamic lesions can cause an increase in sex drive. Other contributory factors could be cognitive impairment due to dementia itself leading to psychosis, mis-identification, and impaired judgement, psychosocial factors (e.g. lack of partner/privacy) or drugs (e.g. L-dopa).
- Assessment of ISB should include a history of the ISB and its context, assessment of mental health (including psychosexual history and mental capacity to consent to the sexual behaviour), physical health, social needs and risk assessment. It is important to establish that the behaviour in question is definitely inappropriate.

**Ethical issues**

- ISB and its management pose several ethical dilemmas particularly around consensual sexual relationships within institutional settings, use of anti-libidinal drugs, restraining clothes, the extent of sexual expression among the long term care residents with dementia etc.
- As a basic human right, every individual should be assumed to have capacity and the right to sexual pleasure unless proved otherwise. Every effort should be made to facilitate appropriate expression of sexuality and not to eliminate it.
Treatment – non-pharmacological approaches

- There are no practice guidelines available for the treatment of ISB in the cognitively impaired elderly population. The aim should be to accept and promote appropriate expression of sexuality. The evidence in support of any treatment approach is not very robust, though underlying cause, if identified, should always be addressed first.

- Non-pharmacological measures should be the first-line treatment and medicines should only be added as an adjunct when these measures fail. Simple common-sense measures could be very effective, for example reminders, explanations, redirection, separation, distraction, providing privacy, stimulating and structured environment, inclusion of physical contact or touch in day to day care and avoiding any cues which could be misinterpreted by the patients. Use of restraining clothes could be helpful but raise ethical dilemmas.

- Family members should always be involved in the assessment and management of such behaviours. Spouses of patients with ISB require support and reassurance.

- Training and changing the staff attitude at care homes can help them to manage this problem.

Treatment – pharmacological approaches

- There are no drugs currently licensed in the UK for the treatment of ISB in people with dementia. Evidence for drug treatments is mainly in the form of case reports, case series and uncontrolled trials.

- In general, unless the patient is engaging in or threatening dangerous acts involving physical contact, serotonergics (first choice, SSRIs; second choice, TCAs) are first-line agents. Antipsychotics (quetiapine, haloperidol) and hormonal treatment like anti-androgens (medroxyprogesterone acetate, ciproterone acetate, cimetidine), oestrogens, and LHRH analogues are also found to be effective. There is some evidence to suggest that carbamazepine, valproic acid, rivastigmine, pindolol and gabapentine are also worth considering.

- Family members should always be consulted and side effects should be explained before starting medications.

- Medications should be started at low dose, increased slowly and reviewed regularly for side effects and effectiveness.

References


