Sexuality and intimacy | Te taeratanga me te kauawhiawhi

Sexuality and intimacy is a normal part of life for all adults

Enjoyment of physical intimacy and sexuality does not cease just because someone is older or lives in residential aged care.

It is a basic human right to be able to express sexuality.

It is important to view sexuality in terms of these rights that include:

- the right to be treated with respect
- the right to be free from discrimination and exploitation
- the right for dignity and independence
- the right to give informed consent.

However, sexual expression by aged care residents can be uncomfortable for staff, other residents and families/whānau. It is important for facilities to have a sexuality policy. This should include:

- an antidiscrimination policy
- policies and procedures to ensure privacy and the resident's dignity
- policies and procedures to ensure expression of sexuality in a safe and tolerant environment.

It may be difficult for staff to balance resident's needs for privacy against their need for personal care. Staff should also respect the confidentiality of relationships between residents. Staff do not have to disclose information to relatives and other parties.

- Sexually transmitted diseases are possible at any age.
- Develop a confidential care plan around the resident's sexuality needs.

Consenting to sexual relations

People with dementia in care homes may form new sexual relationships with other care home residents. As long as both parties agree and have capacity to consent to these relationships, then care home staff should respect such relationships.

How to determine the capacity and risk to the individual:

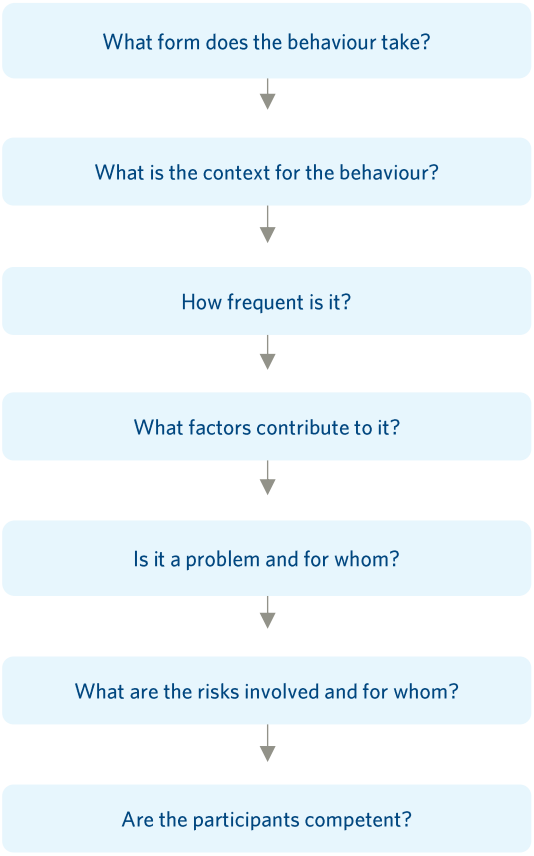
- To what extent are the residents involved capable of making their own decisions?
- Does the resident with dementia have the ability to recognise the person with whom they are having the relationship? Could they have mistaken the person for their original partner?
- Is the resident with dementia capable of expressing their views and wishes within the relationship through either verbal or nonverbal communication?

- Can the residents involved understand what it means to be physically intimate?
- What is the resident's ability to avoid exploitation?
- What is the resident's ability to understand future risk?
- How may the resident be affected if they are ignored, rejected after intimacy or the relationship ends?

Based on the work of Lichtenberg (1997) and Lichtenberg and Strzepek (1990).

Sexually disinhibited behaviour

There may be some people with certain types of cognitive impairment to exhibit disinhibited sexual behaviour. It is important to do an assessment of the situation and determine the following:



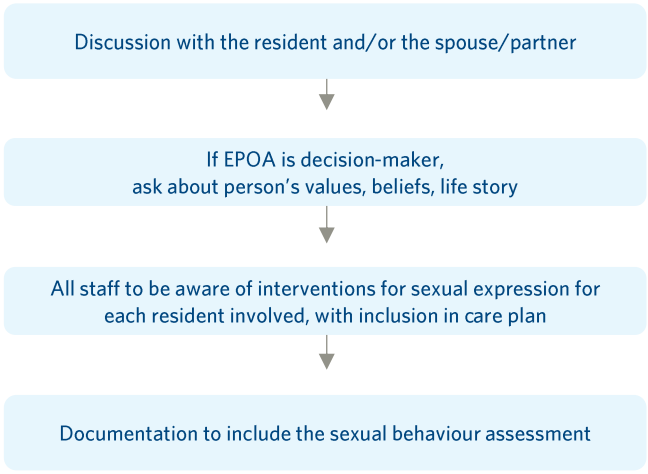
Sexual behaviour – levels of concern

Description of sexual behaviour	Response
Concern level 1 Intimacy/courtship: • Kissing, hugging, handholding, fondling, cuddling (not inclusive) • Consensual (implies awareness of actions)	**No concern associated with this behaviour if both persons are consenting** Overall goal of staff response is to provide socially appropriate context for relationship that offers comfort and reassurance: • This behaviour is viewed primarily as companionship, an intimacy relationship between two adults who are mutually consenting, implied by interactions with no evidence of distress. • Source of urgency associated with this behaviour is usually staff and/or family/whānau discomfort. Staff may wish to protect the family/whānau. • The couple should have intimacy needs recognised and privacy respected.
Concern level 2 Verbal sexual talk: • Flirting, suggestive language, sexually laden language • Non-aggressive or threatening	**Low level of concern associated with this behaviour** • This behaviour may cause discomfort and reaction when directed towards staff, often occurring during personal care. • Staff should respond respectfully. • If suggestive language directed at co-resident, visitor or staff, the behaviour should be redirected into a more socially appropriate context. • Punitive language cannot be tolerated. An example of an appropriate response: 'John, would you like to have a chat? Why don't you tell me about your wife/partner...'
Concern level 3 Self-directed sexual behaviours: • Masturbating in public • Exposing oneself	**Low level of concern** For self-stimulating behaviours, the staff need to observe and answer the following questions: • Is this responsive behaviour an attempt to communicate, eg, a full bladder, discomfort, infection? • Does the person engage in this behaviour in the presence of others? The act is not inappropriate rather the environment may be socially inappropriate when needs for privacy are not met. • Focus on maintaining privacy, dignity, safety and least amount of restriction as possible. • Staff education may be necessary to remind caregivers to provide care without judgement, teasing or ridicule.
Concern level 4 Physical sexual behaviours: • Directed towards co-residents with agreement • Directed to resident by companion/spouse/partner with agreement • Risk immediately increases when sexual expression involves a partner	**Moderate level of concern with this behaviour** • In early dementia, the capacity to make decisions regarding basic needs and immediate gratification, such as sexual activity, is retained. • Staff must be vigilant about observing the resident(s) for any signs of sexual overtures that are unwelcome: objective knowledge of the extent of sexual expression; one-on-one contact with the intent to kiss and caress, disrobing, oral sex or attempt to engage in penetrative intercourse. • Does resident present as distressed, upset, worried, anxious or exhibit any behaviour eliciting concern? • Can the residents give an account of behaviours they would find acceptable/unacceptable? • Do they have the ability to say 'no' or indicate refusal and/or acceptance? • Do they have the ability to avoid exploitation? • If the resident is distressed or non-consenting, move to level 5. • If the resident(s) is incapable of making decisions regarding their sexual expression, it is critical to have EPOA involvement to establish resident's previous wishes, values and beliefs, and to work with the team about **decisions that act in the best interest of the resident.** • The focus of interventions should be on creative solutions that allow the consenting couple privacy and dignity plus opportunities to engage in social activities with others in a socially appropriate context.

Sexual behaviour – levels of concern continued

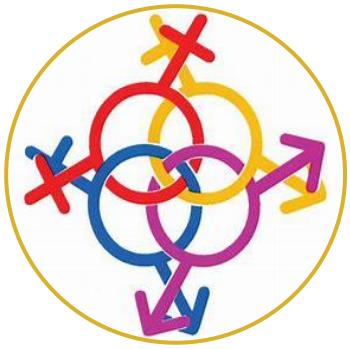
Description of sexual behaviour	Response
Concern level 5 • Non-consensual, overt physical sexual behaviours directed towards others that are a source of distress	A high level of concern is associated with this series of behaviours • A resident may enter another's personal space and clearly touch them in a way that is unwelcome and upsetting for the person. This could range from sexual touching to penetrative sexual intercourse. • The response indicates the person is objecting and the staff view it as an unwanted invasion of personal space. • The appropriate staff response is to protect the resident/others from unwelcome sexual behaviour. The resident who is expressing overt sexual behaviour should be treated with respect and dignity and should not be ostracised. • What is the awareness of the known sexual behaviours: one-on-one contact with the intent to kiss and caress, disrobing, oral sex, or an attempt to engage in penetrative intercourse? • Is there any known history of sexually transmitted infections?
• Aggressive or repeated sexual overtures that are unwanted and rejected by others in the environment	For this type of sexual behaviour, there **must be**: • holistic assessment of possible causes or triggers to the behaviour and any evidence of injury • referral to the geriatric mental health outreach team • awareness of actions: an assessment of resident(s) • NP/GP clinical assessment of the person, if there has been any type of assault.

Discuss and document



Caring for sexual- and gender-diverse people

- Lesbian
- Gay
- Bisexual
- Trans-gender
- Queer
- Intersex



Caring for sexual- and gender-diverse people

- All staff should avoid making any assumptions about gender identity and sexual orientation, just as they should avoid assuming racial identity, age and other characteristics.
- Providers should always work from the premise that they have LGBTQI+ people in their service, even if no one has openly identified as LGBTQI+.
- Create an opening for LGBTQI+ clients to talk about family members of choice by asking them open-ended questions, such as 'Who do you consider family?' or 'Who in your life is especially important?'
- Do not assume you can identify LGBTQI+ individuals by appearances, experiences or external characteristics.
- Ask about sexual orientations and gender identities in a safe and confidential manner.
- Do not use any disrespectful language or express surprise at someone's orientation or sexual identity.
- Do not gossip with others about a patient's orientation, appearance or behaviour.
- Use the terms that people use to describe themselves and their partners, eg, if someone calls himself 'gay' do not use the term 'homosexual'. If a woman refers to her 'wife' then say 'your wife' when referring to her; do not say 'your friend'.
- While taking a history, do not use words that assume people have an opposite-sex partner or spouse, eg, instead of 'do you have a boyfriend or husband?' ask 'do you have a partner?'
- Review documentation: does it include a way to identify partners other than 'husband and wife?'
- Be aware that there are a wide range of sexual and gender identities and expressions and these can change over time, eg, some people 'come out' late in life after having been in a long-term heterosexual marriage.

Caring for transgender older people

- All providers have a duty to deliver services that are respectful of our transgender community.
- Review service documentation; it needs a way to allow a person to enter their preferred name, gender identity and pronouns. This allows all staff to see the patient's preferences and to use them consistently.
- Use the patient's correct pronouns (he/him, she/her, they/them, etc) and preferred name. If you are not sure how the person wishes to be addressed, politely ask.
- Be aware of local support services, groups, resources and relevant referral pathways for transgender people.
- Do not confuse being transgender with sexual orientation. Transgender people can be heterosexual, lesbian, gay, bisexual, asexual, takatapui, queer, etc.
- Recognise gender as fluid, or as a spectrum; not all transgender people want to 'achieve' or 'pass' as the opposite gender to what they were assigned at birth. Many people are comfortable in a space between masculine and feminine, and this is not a reason to withhold gender-affirming treatments.
- If you are unsure how the person would like to be cared for, politely ask rather than assuming.

See: *www.health.govt.nz/our-work/preventative-health-wellness/delivering-health-services-transgender-people*

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