Sexual disinhibition in Alzheimer's disease

When a patient with dementia displays inappropriate sexual behaviour, this often upsets the equilibrium of patient care. This is often when primary care and old age psychiatry services become involved. **Drs Simon Manchip** and **Vandana B Menon** provide an update on the various aspects related to sexual disinhibition in dementia with specific emphasis on the wider implications, such as involving vulnerable adult services.

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Neil Hunt, chief executive of the Alzheimer's Society, said: 'Dementia is one of the main causes of disability in later life.' Dementia has a big impact in many spheres — on the patient, carers, staff resources and agencies involved. When a patient with dementia displays inappropriate sexual behaviour in any setting — for example, a nursing home — this upsets the whole atmosphere of the residence. In such circumstances, it becomes important to manage the situation as well as to educate and discuss the issues with the family and the carers involved.

Nature of disinhibited behaviour

There is no particular definition as to when behaviour becomes abnormal; it is usually based on the assessment of the particular behaviour pertaining to the situation. The disinhibited behaviour varies in severity and frequency but typically persists. It can start either suddenly or insidiously. Premorbid patterns of sexual activity and interest can dictate a strong effect that continues after the development of dementia. From the practical point of view we can divide it into three main categories (*see Table 1*):

- Sexual verbal: for example, sexualised comments with or without the use of abusive language directed at the staff/patients/other residents
- Sexual physical to self: for example, masturbating in private or public places
- Sexual physical to others: for example, touching/grabbing (staff/residents/visitors) in erogenous zones. The various behaviours include sexual comments, touching someone other than a partner on the breast or genitals, touching a partner on the breast or genitals in public, exposing breasts or genitals in public.

Table 1. Categorising sexual behaviour

Sexual verbal
- Sexualised comments without swearing to staff
- Sexualised comments without swearing to other patients/residents
- Sexualised comments with swearing to staff
- Sexualised comments with swearing to other residents/patients

Sexual physical to self
- 'Fiddling' in private area without erection
- 'Fiddling' in public area with erection
- Masturbating in private area without erection
- Masturbating in public area with erection

Sexual physical to others
- Grabbing staff sexually
- Grabbing staff's erogenous zones
- Attempting oral sex with staff
- Attempting penetrative sex with staff
- Grabbing patients/residents sexually
- Grabbing patients/resident's erogenous zones
- Attempting oral sex with patients/residents
- Attempting penetrative sex with patients/residents
- Attempting sexual acts with objects.

Prevalence and causes

Studies of prevalence of sexually disinhibited behaviour in dementia report it to be between two and seven per cent. A study has found that 6.9 per cent of 178 people with Alzheimer's disease living at home, in residential care or in hospital showed sexually inappropriate behaviour, with about equal frequency in men (eight per cent) and women (seven per cent)[1]. There was a significant positive association with severity of dementia. Another study where caregivers of 55 people with dementia were interviewed found that only one family (two per cent) reported the occurrence of inappropriate sexual behaviour[2].

Many causes have been postulated. Often it is due to a combination of them:

> *Organic:* There is some evidence relating changes in sexual behaviour to frontal and temporal lobe pathology. Sexual disinhibition is a known feature of frontal lobe lesions. This may be due to a disturbance in the normal cerebro-cortical inhibitory mechanisms, so that sexual feelings are no longer kept in check.

> *Drugs and alcohol:* Alcohol can impair cognition and thereby results in sexual disinhibition both in normal and in those with dementia. Brain injured patients being more vulnerable. Paradoxical disinhibition can be on the odd occasion seen with benzodiazepines[3]. Levodopa has been reported to cause hypersexuality when used in Parkinson's disease[4,5]. Both of these drugs can precipitate sexual acting out.

> *Psychosocial:* It has been suggested premorbid patterns of sexual activity and interests have a strong effect on the behaviour exhibited. Lack of usual sexual partner, as well as lack of privacy in nursing homes, can result in inappropriate public behaviour. It is recognised that patients tend to misinterpret cues picked up from their surroundings — for example, misinterpreting the actions of female carers providing regular personal care. Either this behaviour can be due to the prevailing mental state where they can be depressed or manic, which is common in dementia, or it can be due to psychotic symptoms; for example, having delusions of misidentification (believing another resident is their wife/husband).

Assessment

The primary stage of assessment is to obtain a full history from the patient or caregivers — which can be a challenge if the patient has no insight. A thorough psychiatric interview should include a full psychosexual assessment and sexual history as well as mental state examination to rule out psychotic symptoms or mania. A simple, well-situated method — one often recorded by staff — is carefully looking into what is known as 'ABC' (antecedents, behaviour, consequences). A detailed physical examination and relevant investigations to rule out comorbid medical conditions, like chest infections or urinary tract infections, is also useful.

Nursing homes will be concerned about the reaction of families, the effect on other residents and the role of the local inspection units in disinhibited behaviour. It is important to see where the issues truly lie, whether it is the behaviour that is the primary concern or the care home's reaction to the behaviour. Sometimes younger carers may struggle to realise that older people can still be sexually active and the main issue is not the extent of the behaviour but the home's ability to understand and deal with the behaviour.

When the sexual behaviour involves two patients, the assessment should also include assessing the capacity to engage of the two adults involved in the sexual behaviour both the 'perpetrator' (patient suffering from dementia) and the 'victim'(another patient who lacks capacity to engage in the process of sexual behaviour). For instance if there are two people involved in the sexual activity both of them may need an assessment of their mental capacity to engage in the activity. Obviously, if both are able to consent there is no mental health disorder but if one or both cannot give informed consent this should be regarded as potential sexual abuse.

Management

Management can be seen as a combination of behavioural, education and pharmacological interventions. This particular situation raises the anxiety of all the people involved who all would like some kind of instant result. In fact, there is little published evidence available on the use of medications. The main aim is safety of the 'victim' and, at the same time, respect for their dignity of all involved. Depending on where they are, the incident has to be reported by filling in a clinical incident form. Any notable sexual act on a patient 'victim' lacking capacity requires a possible referral to a local vulnerable adult unit as shall be discussed further along.

Behavioural and educational intervention

There are no published reports that describe specific behavioural management in this situation. The important issue is how successfully you can teach new skills to a patient who already has difficulties in learning. However, the first step is to explain delicately why such behaviour is not acceptable in a non-confrontational way. The simplest way is to discourage any inappropriate behaviour — for example, by paying less attention to it. Desirable behaviour can be reinforced with a reward. This might reduce the unwanted behaviour. The lack of privacy in most nursing homes may force patients to express sexual behaviour overtly. Another important step in management is tackling the nursing staff's attitude towards sexuality and dementia. A sex education programme with relation to dementia might change the outlook of the staff and thereby improve the quality of the life of long-term patients. Educating the individual on alcohol, if this has repercussions on their behaviour, may be beneficial.

Pharmacological intervention

The primary measure is always treatment of the cause — for example, are there any infections that may the trigger the behaviour? In situations where the person is agitated, at risk and an immediate remedy is required, we have to resort to pharmacotherapy. Currently, there is no drug licensed in the UK for the treatment of sexual disinhibition in patients having dementia. This means in patients without capacity, extra thought has to be given to the risk/benefit. Under the Mental Capacity Act, the views of the relatives may have to be brought in. There are six classes of drugs currently used, even though all are off license for sexual disinhibition. The various classes of drugs are neuroleptics, antidepressants, antiandrogens, oestrogens, LHRH analogues and antiepileptics.

Neuroleptics

This may be the most commonly used in treatment of inappropriate behaviour even though there is little published evidence concerning efficacy of these medications. One should be very cautious in using in patients with dementia, as there is an increased risk of cardiovascular events highlighted by the Committee of Safety of Medicines with olanzapine and risperidone[6]. They can also cause side effects like extrapyramydal symptoms, hypotension and sedation. The antipsychotic are often used in combination with benzodiazepines, though the latter can cause paradoxical dishinibition[6].

Table 2. Vulnerable adult procedures

Consideration of the initial referral
Pre-early strategy meeting actions
Early strategy meeting
Joint investigation/single agency investigation
Adult protection case conference
Adult protection plan
Adult protection review

Antidepressents

Selective serotonin reuptake inhibitors (SSRIs) are a group of antidepressants that can be efficiaous in treatment of sexual disinhibition. It is postulated that the antiobsessive property of SSRIs is useful along with the antilibidinal effects. This group can be used in uncomplicated cases of early dementia with sexual disinhibition and studies have shown[7] that they should be started and stabilised at a very low dose.

The other advantage is of a safer side effect profile than neuroleptics. Tricyclic antidepressants, especially clompiramine, which inhibits serotonin reuptake are effective, but one is usually limited due to the side effects profile[8,9] — such as sedation, constipation and urinary retention —which can lead to agitation. It is also known to cause confusion in the elderly group.

Hormones

The advantages of using neurohormones are quick response and ease of administration. The availability of oestrogen patches is a useful alternative, particularly for elderly demented patients with sexual disinhibition that have comorbid medical illness. However, it is particularly risky if patients have a cardiovascular disease or thromboembolism. Nevertheless, it can cause side effects, such as nausea and water retention. In two studies where men with sexual disinhibition and dementia were administered IM medroxyprogesterone acetate once every one to two weeks, the inappropriate behaviour stopped[10]. Some practitioners use finasteride based on the assumption that lowering testosterone (in both man and woman) could reduce the behaviour.

Key points

- Sexual disinhibition is a common problem particularly in care homes.
- There are statutory policies on abuse of vulnerable adults that must be adhered.
- There are various methods that might reduce the disinhibition.
- Assessment of the person's capacity to engage in sexual behaviour is crucial.
- Management usually involves multidisciplinary care.

Antiepileptics

It was shown that behavioural problems in Alzheimer's dementia are due to deficits in gamma aminobutyric acid (GABA) and gabapentin is known to increase the GABA synthesis. In a nursing home study, patients having behavioural problems with a diagnosis of Alzheimer's disease and vascular dementia, sexual disinhibition was effectively controlled with gabapentin[11]. It is also relatively safe to use in elderly.

Vulnerable adult procedures

Any mental health worker involved with the care a vulnerable patient must be aware of the possibility of abuse. A vulnerable patient can be thought of as anyone not able to give full consent to sexual activity by reason of a mental disorder such as learning disability, dementia or depression. Where a person is in immediate danger, the appropriate emergency services (eg, social services, police) have to be alerted. In some situations, the vulnerable adult might have to be removed from the environment; for example, placed in a residential home or another home. The primary role for investigation rests with the qualified practitioners in social services, the local community mental health team, the police, and the registration and inspection service for care homes. The investigating officer has to ensure they adhere to the local policy and guidance. The investigatory planning and resulting action can be a complex and time-consuming task, but is vital to ensure there is clarity about the purpose and extent of the investigation. They have to evaluate the evidence gathered during the investigatory process from the different inter-agencies and finally make a decision about the likely risk and thereby take the necessary actions to safeguard the vulnerable adult.

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Conclusion

Sexual disinhibited behaviour is quite common in dementia. There can be a number of causes and whenever it arises, it can be very complex to deal with. The behaviour needs close evaluation and assessment while, at the same time, maintaining the dignity and safety of the patients and carers involved. The management is a combination of targeting the attitudes and beliefs of the staff and carers with further education, and modifying the environment factors. However, one might have to initially medicate, especially when the patient is agitated/aggressive. The vulnerable adults unit should be informed as early as any abuse is suspected. In all cases of perceived sexual abuse that involves physical contact beyond kissing it should be discussed with them. Not all cases need to proceed to a full investigation but it is proper to have at least raised the issue with them, often a brief telephone call is all that is required.

Conflict of interest: Dr Simon Manchip lectured and attended advisory boards for Lundbeck and Pfizer.