

THE ETERNAL FLAME: CAPACITY TO CONSENT TO SEXUAL BEHAVIOR AMONG NURSING HOME RESIDENTS WITH DEMENTIA

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As the elderly population increases, both the number of elderly individuals suffering from dementia and the number of elderly individuals living in nursing homes increase. Dementia presents a serious problem in nursing homes where elderly individuals wish to engage in sexual intimacy. Despite the fact that most elderly individuals want to engage in sexual activity, most nursing homes and nursing home staffs are reluctant to allow such behavior because of the individuals' diminished capacity to give consent. In response to this dilemma, nursing homes have looked at different methods to determine whether a person has the capacity to consent to sexual activity. One potential method of determinations comes from courts; courts, however, vary by jurisdiction in their determinations of a person's capacity to consent to sexual activity and rarely have decided the issue of whether an individual with dementia has such capacity to consent. Nursing homes, therefore, often must make their own determinations regarding a dementia sufferer's capacity to consent to sexual activity. In response, nursing homes generally use two different methods: the case-by-case method, which is used by more liberal institutions, and the Mini-Mental State Examination, a standardized test used by more conservative institutions. Both of these methods, however, have their pitfalls, and, thus, scholars and concerned individuals alike have proposed many other alternative solutions, such as "limited capacity" systems, guardianship, and training and education for nursing home staffs, residents, and residents' families. This Note proposes that in order to best serve the

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interests of nursing home residents, especially those suffering from dementia, nursing homes should implement a combination of a system of limited capacity determination as well as increased training and education for nursing home staffs, residents, and residents' families.

I. Introduction

Bob and Dorothy have dementia.¹ Dorothy lost her husband sixteen years ago to a heart attack, and Bob has outlived three previous wives. Before Dorothy moved into the nursing home, many women were vying for Bob's attention. But the manager of the nursing home could tell that once Bob met Dorothy, "it was love."² When Bob saw Dorothy, he would light up "like a young stud seeing his lady for the first time."³ Bob and Dorothy soon were spending all of their free time together. They continued their love affair until Bob's son realized that their relationship had become sexual. Bob's son assumed that his father was being taken advantage of—that due to his dementia, he could not adequately understand the relationship and that Dorothy's advances might "be hard on his father's weak heart."⁴ Bob's son insisted that his father be transferred to a different nursing home and refused the nursing home manager's request to let Dorothy say goodbye. For a while, Dorothy stopped eating. She lost over twenty pounds and was treated for depression. In a twisted turn of events, her doctor believes that her Alzheimer's may have saved her life. "[T]he loss might have killed her if its memory hadn't faded so mercifully fast."⁵

Far too often, sexuality among the elderly and those with cognitive impairments is ignored or invalidated. It is a widespread belief that older people are not sexually active—that sexuality is something possessed exclusively by the young.⁶ This inaccurate perception has caused some nursing home residents to lose their rights to sexual in-

1. Melinda Henneberger, *An Affair to Remember*, SLATE, June 10, 2008, <http://www.slate.com/id/2192178> (names changed in original).

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. See Rob Stein, *Elderly Staying Sexually Active*, WASH. POST, Aug. 23, 2007, at A01, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/08/22/AR2007082202000.html>.

timacy.⁷ Because it is often the case that those whose sexual rights have been infringed upon are neither competent nor financially stable enough to protect themselves through the resources of the legal system, it is important to be diligent in examining this issue and finding the optimal solution.⁸

Individuals with dementia often are deemed to lack capacity and, therefore, are found to be incapable of providing valid consent to any kind of sexual behavior.⁹ When evaluating capacity, it is important to balance the individual with dementia's right to sexual expression with the nursing home's need to provide a safe environment and protect residents from harm.¹⁰ Most nursing homes err on the side of caution, which unfortunately often can be detrimental to these individuals.¹¹ Rather, the aim of care providers should be to permit these individuals to engage in sexual intimacy as long as the associated risks can be sufficiently minimized.

This Note addresses the capacity of nursing home residents with dementia to consent to sexual activity. Part II rebuts the myth that "old people don't have sex" and introduces background information regarding dementia, intimacy, and nursing homes' reluctance to allow residents to engage in sexual activity. Part III analyzes how current methods address the capacity to consent to sexual activity among individuals with dementia. Finally, Part IV advocates additional training and information sharing for nursing home staffs, residents, and residents' families to address the sexuality of nursing home residents

7. See Andrew Casta-Kaufteil, *The Old & the Restless: Mediating Rights to Intimacy for Nursing Home Residents with Cognitive Impairments*, 8 MICH. ST. J. MED. & L. 69, 71 (2004).

8. See *id.* at 76 ("Alzheimer's disease is progressive, and ultimately leads to one's mental and physical demise. As a result, the litigation process is inappropriate, insofar as its unconscionable length, inherent emotional turmoil, and high possibility for relocation, is concerned.").

9. See Kathleen S. Mayers, *Sexuality and the Demented Patient*, 16 SEXUALITY & DISABILITY 219, 223 (1998) ("If the patients involved in sexual activity are moderately to severely demented, the term 'consensual' cannot be applied to their sexual activity. A patient civilly committed under the supervision of the state may not have the mental capability to make a choice to engage in sexual activity.").

10. Compare *Griswold v. Connecticut*, 381 U.S. 479, 484–86 (1965) (holding that there is a constitutional right to privacy, including the right to make reproductive decisions), with *Youngberg v. Romeo*, 457 U.S. 307, 315–16 (1982) (holding that the Due Process Clause of the Fourteenth Amendment affords individuals residing in institutions the right to safe conditions).

11. See Casta-Kaufteil, *supra* note 7, at 71 ("The taboo nature of sex amongst the elderly and cognitively impaired, combined with a marginal benefit-marginal cost analysis, results in nursing homes erring on the side of caution, in ultimately deterring intimacy amongst residents.").

with dementia, as well as the use of a limited capacity method for resident capacity determinations.

II. Background

A. The Aging Population

The importance of caring for the needs of the elderly, especially those who suffer from cognitive impairments, is only increasing as the population ages. The American population of those aged sixty-five and older is expected to reach approximately seventy million by the year 2030—more than double the number of seniors as of 1998.¹² As the elderly population grows, so does the number of elderly individuals who suffer from cognitive impairments.¹³ As of 2004, there were four million Americans living with Alzheimer's disease.¹⁴ That number is expected to more than triple, reaching fourteen million by 2050.¹⁵ Because dementia is a progressive and terminal condition, a patient's capacity becomes increasingly limited.¹⁶ Thus, bringing any kind of legal action to assert her rights is difficult when the condition is mild and becomes virtually impossible as the condition becomes more severe.¹⁷

Approximately 1.6 million people are living in nursing homes in the United States.¹⁸ To qualify for Medicare and Medicaid programs, these facilities must comply with the requirements outlined in the United States Code of Federal Regulations.¹⁹ Although these requirements do not specifically address a nursing home resident's right to sexual intimacy, there are provisions regarding "resident privacy, dignity, and quality of life."²⁰ These provisions provide that a facility must "care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of

12. Erica Wood, *Dispute Resolution and Dementia: Seeking Solutions*, 35 GA. L. REV. 785, 788 (2001) (citing ADMIN. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., A PROFILE OF OLDER AMERICANS: 2000 (2000), http://www.aoa.gov/AoAroot/Aging_Statistics/Profile/2000/profile2000.pdf).

13. Casta-Kaufteil, *supra* note 7, at 70.

14. INJURIES AND DISORDERS IN THE ELDERLY § 12.02 (David L. Kaufman ed., 2000).

15. See Casta-Kaufteil, *supra* note 7, at 70.

16. *Id.* at 82.

17. See *id.* at 76.

18. *Id.* at 70.

19. *Id.* at 71.

20. See 42 C.F.R. § 483.10(e)(1), .15-.15(a) (2008).

life”²¹ and “promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.”²² Additionally, the requirements provide for privacy and confidentiality in “accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.”²³ These requirements all seem to indicate that nursing home residents have the right to create and maintain interpersonal relationships, including relationships of a sexual nature.

B. Dementia and Alzheimer’s Disease

Contrary to a common misconception, dementia is not a disease but instead is a condition that can be brought on by a wide range of causes.²⁴ Dementia is defined as a progressive loss of cognitive function sufficient to impair performance of everyday activities.²⁵ While it may occur at any age of adulthood, dementia occurs most frequently in the elderly.²⁶ Alzheimer’s disease is the most common cause of dementia.²⁷ It accounts for sixty to seventy percent of dementia cases²⁸ and is the seventh-leading cause of death in the United States.²⁹ Alzheimer’s disease deteriorates and destroys brain cells, causing problems with memory, thinking, and behavior.³⁰ Less than ten percent of dementia cases are due to causes which are potentially reversible; the vast majority of dementia symptoms are irreversible and are accompanied by continuous brain cell deterioration.³¹

21. § 483.15.

22. § 483.15(a).

23. § 483.10(e)(1).

24. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: TEXT REVISION 151 (4th ed. 1994) [hereinafter DSM-IV-TR].

25. See *id.* at 134; Charles P. Sabatino, *Representing a Client with Diminished Capacity: How Do You Know It and What Do You Do About It?*, 16 J. AM. ACAD. MATRIMONIAL LAW. 481, 481–82 (2000).

26. See DSM-IV-TR, *supra* note 24, at 137.

27. *Id.* at 137; INJURIES AND DISORDERS IN THE ELDERLY, *supra* note 14, § 12.00.

28. Sabatino, *supra* note 25, at 482.

29. Alzheimer’s Association, *What Is Alzheimer’s*, http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp (last visited Jan. 15, 2010).

30. *Id.*

31. See A. Mark Clarfield, *The Decreasing Prevalence of Reversible Dementias*, 163 ARCHIVES INTERNAL MED., 2219, 2219–20, 2224 tbl.3 (2003), available at <http://archinte.ama-assn.org/cgi/reprint/163/18/2219> (“Potentially reversible causes were seen in 9% [of dementia cases], and only 0.6% of dementia cases [were] actually reversed.”).

There is currently no known treatment to cure, delay, or prevent the brain cell deterioration associated with the progression of Alzheimer's disease.³² At present, a few medications are on the market, including the most widely distributed, donepezil and memantine, which are believed to cause an improvement in the cognitive processes of individuals with dementia.³³ However, these medications generally offer only temporary and limited therapeutic benefit³⁴ and are looked upon with skepticism by many in the medical community.³⁵ As one psychologist who works in nursing homes stated, "[a]t best, these effects [from dementia medications] may be only marginally more effective against dementia than garlic was against the Black Death in the 14th century."³⁶ The medications generally are more effective in mild dementia cases and less effective or not available in moderate to severe dementia cases.³⁷ Further, there has been no definitive confirmation to the claims that these medications are able to alter the progression of Alzheimer's disease.³⁸

C. Perceptions of Elder Sexuality

There are two common and conflicting stereotypes about elder sexuality:³⁹ the elderly are perceived as either asexual or hypersexual.⁴⁰ They are imagined to be wholly disinterested in sex or to be inappropriately interested to the point of perversion, as typified by the stereotype of the "dirty old man."⁴¹ Both generalities are inaccurate and insulting to the elderly community.⁴²

32. See Alzheimer's Association, Alzheimer Myths, http://www.alz.org/alzheimers_disease_myths_about_alzheimers.asp (last visited Jan. 15, 2010).

33. See Ira Rosofsky, *The Comfort Prescription*, L.A. TIMES, Mar. 19, 2009, at A29 ("[D]onepezil and memantine . . . together account for more than 90% of the anti-dementia drug market.").

34. INJURIES AND DISORDERS IN THE ELDERLY, *supra* note 14, § 12.00.

35. See, e.g., Rosofsky, *supra* note 33, at A29.

36. *Id.*

37. *Id.* ("Donepezil can be prescribed only by a psychiatrist or a neurologist, and its use is restricted to cases of mild to moderate—not severe—dementia.").

38. See New York Times.com, Alzheimer's Disease In-Depth Report, <http://health.nytimes.com/health/guides/disease/alzheimers-disease/print.html> (last visited Jan. 15, 2010).

39. Kathleen S. Mayers & Dennis McBride, *Sexuality Training for Caretakers of Geriatric Residents in Long Term Care Facilities*, 16 SEXUALITY & DISABILITY 227, 230 (1998).

40. See *id.*

41. *Id.*

42. *Id.*

There is very limited research on sexual intimacy among nursing home residents.⁴³ The social stigma associated with sex among the elderly and the cognitively impaired oftentimes causes people to either actively or passively ignore the subject.⁴⁴ At the 2007 Alzheimer's Association annual conference, one seminar focused on sexuality and dementia.⁴⁵ During the discussion, many attendees raised the complaint that nursing homes do not permit the kind of privacy which would allow for intimacy.⁴⁶ "[The] doors don't lock and rooms are often shared[,]” said one participant.⁴⁷ In some situations, conjugal visits are completely prohibited even from a resident's long-term partner.⁴⁸ Furthermore, many people at the conference complained about the nursing home staff's contemptuous reactions to any displays of intimacy.⁴⁹ Staff often frame sexuality in the nursing home in a negative light, which can cause feelings of shame, guilt, and inadequacy among residents.⁵⁰ One woman recounted an instance in which she was reprimanded by a member of the nursing home staff for snuggling, fully clothed, in bed with her husband during a visit.⁵¹

According to Stacy Lindau, who led the first detailed examination of sexuality among older Americans (aged fifty-seven to eighty-five), “[t]here's a popular perception that older people aren't as interested in sex as younger people Our study shows that's simply not true. Older people value sexuality as an important part of life.”⁵² Lindau's study showed that seventy-three percent of fifty-seven- to sixty-four-year-old respondents, fifty-three percent of sixty-five- to seventy-four-year-old respondents, and twenty-six percent of seventy-five- to

43. Casta-Kaufteil, *supra* note 7, at 72 (citing Steven H. Miles & Kara Parker, *Sexuality in the Nursing Home: Iatrogenic Loneliness*, 23 GENERATIONS 36, 37-38 (1999)).

44. *Id.* at 73.

45. Lara Belonogoff, *Sex in Nursing Homes—The Debate Continues*, GILBERT GUIDE, Mar. 23, 2007, <http://www.gilbertguide.com/2007/03/23/sex-in-nursing-homes-the-debate-continues/>.

46. *Id.*

47. *Id.*

48. Daniel Engber, *Naughty Nursing Homes*, SLATE, Sept. 27, 2007, <http://www.slate.com/id/2174855/>.

49. Belonogoff, *supra* note 45.

50. Melinda S. Lantz, *Consenting Adults: Sexuality in the Nursing Home*, 12 CLINICAL GERIATRICS 33, 34 (2004).

51. Belonogoff, *supra* note 45.

52. Stein, *supra* note 6, at A01.

eighty-five-year-old respondents were sexually active.⁵³ Additionally, about three-quarters of all respondents who had partners were sexually active, a level which research previously had associated with adults in their forties and fifties.⁵⁴ These percentages are likely to grow even larger as the availability of new medical treatments like Viagra, Cialis, and Levitra increase and as those who grew up in the sexually liberated 1960s and 1970s enter nursing homes.⁵⁵

Evidence also suggests that sexual activity is not restricted to those elderly individuals in good health.⁵⁶ Elderly dementia sufferers often remain sexually active as well.⁵⁷ One study of forty married couples with one partner suffering from mild to moderate dementia suggested that more than twenty percent of couples remained sexually active.⁵⁸ Of those couples that remained sexually active, all of the partners of dementia sufferers reported satisfaction with their sexual relationships and believed that their partners also were satisfied.⁵⁹ Of those couples who were not sexually active, almost forty percent were dissatisfied with the absence of a sexual relationship, and all but one of those dissatisfied partners believed that their spouses also were dissatisfied.⁶⁰ From this data, the researchers stated that “[i]t is reasonable to assume that [the partners suffering from dementia] would have liked to continue with sexual relations.”⁶¹

A continued sex life can be a source of support, reassurance, and comfort to couples dealing with one spouse’s dementia symptoms.⁶² In another study of Alzheimer’s patients and their caregiver spouses, one spouse declared:

[a]s to our intimacy—we never knew another partner in our life and if we were missing anything we were unaware of it. Up until

53. Stacy Tessler Lindau et al., *A Study of Sexuality and Health Among Older Adults in the United States*, 357 *NEW ENG. J. MED.* 762, 762 (2007), available at <http://content.nejm.org/cgi/content/full/357/8/762>.

54. Stein, *supra* note 6, at A01.

55. *Id.*; Engber, *supra* note 48.

56. See C. G. Ballard et al., *Sexual Relationships in Married Dementia Sufferers*, 12 *INT’L J. GERIATRIC PSYCHIATRY* 447, 448 (1997).

57. *Id.*

58. *Id.* at 449.

59. *Id.*; see also Casta-Kaufteil, *supra* note 7, at 73 (“[E]ven though sexual intimacy in a marriage where a spouse has Alzheimer’s disease decreases, fulfilling sex often continues when dementia is in its most impairing, advanced stages.”).

60. Ballard et al., *supra* note 56, at 449.

61. *Id.* at 450.

62. Edna L. Ballard, *Attitudes, Myths, and Realities: Helping Family and Professional Caregivers Cope with Sexuality in the Alzheimer’s Patient*, 13 *SEXUALITY & DISABILITY* 255, 259 (1995).

Jack could no longer walk, he seemed to know me and would always accept me in our bed in his old familiar way. This was such a comfort to me as his endearments never stopped and though they were whispered in “gibberish” I knew what he meant!⁶³

While the elderly’s need for intimacy persists, this need is often marginalized. According to one survey, over sixty percent of employees at a nursing facility “did not believe it was necessary for residents to maintain sexual activity.”⁶⁴ Displays of residents’ sexuality are often perceived as “behavioral problems rather than . . . expressions of a need for love and intimacy.”⁶⁵ While in most cases dementia causes a reduction in sexual drive, some individuals with dementia display a heightened interest in sexual intimacy.⁶⁶ Increased libido is reported in about fourteen percent of those elderly individuals with dementia.⁶⁷ But even in those dementia cases where the person has lost interest in sex, the person likely will retain the need for physical contact, intimacy, and touch.⁶⁸

Further, because many nursing homes are run by religious groups, the staff may approach resident sexuality from the beliefs and teachings of their respective faiths—in many cases that unmarried individuals should not engage in sexual behavior.⁶⁹ Because many nursing home residents have lost their spouses, this means that many of these residents are completely denied intimacy. In one study, nurses “felt torn between moral norms of the institution and their duties to preserve residents’ rights for privacy and the fulfillment of basic needs.”⁷⁰

As the cognitive abilities of these individuals fade, others may be quick to infantilize them.⁷¹ This is revealed through the way that some caretakers treat those with cognitive impairments, speaking in baby-

63. *Id.*

64. Hosam K. Kamel, *Sexuality in Aging: Focus on Institutionalized Elderly*, ANNALS LONG-TERM CARE, May 2001, at 64, 67.

65. *Id.* at 64.

66. LORI SHINDEL MARTIN ET AL., INTIMACY, SEXUALITY AND SEXUAL BEHAVIOUR IN DEMENTIA: HOW TO DEVELOP PRACTICE GUIDELINES AND POLICY FOR LONG TERM CARE FACILITIES 6 (2002), <http://www.fhs.mcmaster.ca/mcah/cgec/toolkit.pdf>.

67. *Id.*

68. ALZHEIMER SCOTLAND, SEXUALITY & DEMENTIA INFORMATION SHEET 3 (2001), <http://www.alzscot.org/downloads/sexuality.pdf>.

69. Duncan S. MacLean, *Sex: A Matter of Policy?*, CARING FOR THE AGES, Feb. 2002, at 20–21, available at <http://www.amda.com/publications/caring/february2002/sex.cfm>.

70. Kamel, *supra* note 64, at 70.

71. Mayers & McBride, *supra* note 39, at 228–29.

talk or using infantile terms of endearment like “dear” and “sweetie.”⁷² People often describe those suffering from dementia as having regressed into a child-like state.⁷³ When people start to treat these individuals like children, it is easy to understand how such behavior advances the misconception that the cognitively impaired individual should not be interested in sex.

As some patients lose decision-making abilities and begin to need constant care, it raises the question: how do we address these individuals’ sexuality? Do we treat them in much the same way as we do minors, who lack the capacity to consent to sexual activity? This paternalistic approach has serious repercussions for elderly dementia sufferers. With children, the approach merely asks them to wait a few years—until they are older, and can make their own decisions as to their sexual behavior. However, elderly dementia sufferers very rarely are able to regain functioning in a way that would allow for a later finding of capacity, meaning that once an individual is deemed to lack capacity, he or she likely will never again be able to engage in consensual sexual behavior.⁷⁴ It is important to recognize that while an individual may be incapable of making certain decisions, he may remain capable of making other decisions. Therefore, an evaluation of capacity for the purposes of sexual relationships necessitates a specific assessment of the individual’s ability to understand those issues inherent to personal and sexual relationships.

D. The Benefits of Sexual Activity

Sexual intimacy is beneficial to a person’s physical, psychological, and emotional well-being.⁷⁵ Humans are hardwired to crave and

72. *Id.*; E.J. Mundell, *Alzheimer’s Patients React Poorly to ‘Elderspeak’*, WASH. POST, July 28, 2008, <http://www.washingtonpost.com/wp-dyn/content/article/2008/07/28/AR2008072800949.html>.

73. Don Hayen & Jenni Gafford, *The Ideal Nursing Home for Dementia Care*, 9 ALZHEIMER’S CARE TODAY, Apr.–June 2008, at 162, 162.

74. See Engber, *supra* note 48.

75. See Stein, *supra* note 6.

“Individuals who remain sexually active gain the benefit of the physical exercise that comes with sex,” Lindau said. “It’s also possible the hormones—the endorphins released by orgasms—give a general sense of well-being that could be beneficial. The psychological benefits of being loved and cared for may also trickle over to physical health.”

Id.

need physical contact.⁷⁶ Unfortunately, many elderly individuals in nursing homes do not receive an adequate amount of physical contact and, subsequently, experience touch deprivation.⁷⁷ Touch deprivation stems from a lack of tactile stimulation⁷⁸ and can result in unresponsiveness, depression, and even death.⁷⁹ Some research has shown that the elderly, along with the psychotic, are the groups that experience the least amount of touching in a hospitalized setting.⁸⁰ Additionally, most of the touching that is done to the elderly is “instrumental” (that is, required in the carrying out of tasks) rather than ‘expressive’ (that is, to convey acceptance, nurturing and caring).⁸¹

Studies have indicated that individuals who are sexually active benefit from, among other things, a reduced risk of heart disease, better overall fitness, reduced depression, and pain relief.⁸² These potential benefits can be especially advantageous to older individuals residing in nursing homes or to those with diminishing mental capacity.⁸³ One study on the sexuality of older Americans indicated that the likelihood of being sexually active was positively associated with self-reported health.⁸⁴ Arthritis sufferers have reported pain relief for several hours after a sexual encounter.⁸⁵ Additionally, “passionate love, companionship, and satisfying sexual intimacy strongly correspond with life satisfaction and psychological health.”⁸⁶ Some members of nursing home staffs have also observed that residents who have an intimate partner take greater pride in their appearances, display more positive self-images, and enjoy love and intimacy.⁸⁷

76. See Jane A. Simington, *The Elderly Require a “Special Touch”: Touching Expresses Caring, and the Quality of Care Improves*, NURSING HOMES, Apr. 1, 1993, at 30, 30, available at http://findarticles.com/p/articles/mi_m3830/is_n3_v42/ai_13977638 (“One of the basic needs of all human beings is the need for nurturing caring touch.”); see also ALZHEIMER SCOTLAND, *supra* note 68, at 3 (“Although a person with dementia may forget how they used to please their partner and themselves during sex, what they will not lose is the need for intimacy and touch.”).

77. Simington, *supra* note 76, at 30.

78. MOSBY’S MEDICAL DICTIONARY 1864 (8th ed. 2009).

79. Atlanta Legal Aid Society, *Sexuality in the Nursing Home*, <http://www.atlantalegalaid.org/fact20.htm> (last visited Jan. 16, 2010).

80. Simington, *supra* note 76, at 30.

81. *Id.*

82. Alan Farnham, *Is Sex Necessary?*, FORBES, Oct. 8, 2003, http://www.forbes.com/2003/10/08/cz_af_1008health.html.

83. See Casta-Kaufteil, *supra* note 15, at 72–73.

84. See Lindau et al., *supra* note 53, at 765 tbl.A.

85. Casta-Kaufteil, *supra* note 7, at 72.

86. *Id.* at 73.

87. Ballard, *supra* note 62, at 261 (“In integrated settings of males and females, for example, residents often function at a higher level with respect to taking care of

E. Risks Associated with Sexual Activity Among Elderly Dementia Sufferers

In analyzing this issue, it is necessary to balance the individual dementia sufferer's right to sexual expression with the need to protect the individual as a member of a group that may be vulnerable to abuse. The federal government lists regulations in the Patient Bill of Rights that require a nursing home to recognize both the patient's right to "associate and communicate privately with persons of his or her choice, including other patients" as well as a right to be "protect[ed] . . . from abuse, injury, and neglect."⁸⁸ However, these rights potentially come into conflict because "[p]reventing, or even hindering, sexual activity violates their right for freedom, and promoting the right of sexual expression may put them at risk of mental or physical harm."⁸⁹

1. POTENTIAL FOR ABUSE

In a 2005 study of 120 adults, comprised of sixty individuals with intellectual disabilities and sixty without, the adults with intellectual disabilities were "significantly less knowledgeable about almost all aspects of sex and appeared significantly more vulnerable to abuse, having difficulty at times distinguishing abusive from consenting relationships."⁹⁰ However, some adults with intellectual disabilities, especially those who had comparatively higher IQs and those who had received sexuality education, scored highly in all areas.⁹¹

While the common fear that a severely impaired resident will be taken advantage of and not possess adequate skills to report the abuse is valid, it may be overstated. "Even an Alzheimer's patient who has lost the ability to talk can express desire or dismay through sounds, facial expressions, and hand gestures."⁹² In much the same way, nursing home staffs often will be able to gauge when an Alzheimer's pa-

their appearance, greater participation in social activities, increased morale, and an enhanced sense of self-esteem."); see Henneberger, *supra* note 1.

88. Hosam K. Kamel, *Sexuality in the Nursing Home, Part 2: Managing Abnormal Behavior—Legal and Ethical Issues*, 4 J. AM. MED. DIRECTORS ASS'N 203, 204–05 (2003).

89. *Id.* at 205.

90. Glynis H. Murphy & Ali O'Callaghan, *Capacity of Adults with Intellectual Disabilities to Consent to Sexual Relationships*, 34 PSYCHOL. MED. 1347, 1355 (2004).

91. *Id.*

92. Engber, *supra* note 48.

tient expresses a nonverbal desire to engage in the specific conduct.⁹³ Nursing home staff should look to the patient's body language to try to determine what that patient would say if she were capable of communicating verbally. Does the individual appear happy and content, or distressed? Does she repeatedly seek out the behavior, or does she attempt to escape it? Nursing home staff must be observant of resident behavior to prevent and put a stop to any sexual abuse while still respecting the residents' desires for intimacy.

2. FINANCIAL CONCERNS

In addition to the taboo nature of sex among the elderly with cognitive impairments, one of the most compelling reasons nursing homes generally err on the side of forbidding patients from engaging in sexual activity is a fear of expensive lawsuits.⁹⁴ "Simply put, promoting sex could generate high potential liability, while the probability remains extremely low that indigent residents (or their families) will bring suit to enforce their right to sex."⁹⁵ Because of this, it is not surprising that nursing home staff members are hesitant to allow any kind of sexual activity between residents. "[A]dministrators crack down with de facto statutory rape rules that treat elderly patients as if they were teenagers: If they can't be trusted to provide consent, they're automatically treated as the victims of any sexual encounter."⁹⁶

In a 1996 case, an Ohio man sued a nursing home for the right to spend nights with his mentally incompetent wife.⁹⁷ In 1994, Diane Belinky suffered a stroke, which left her incompetent, and she was admitted to a nursing home.⁹⁸ Her husband Barry visited Diane every day during the nursing home's visiting hours.⁹⁹ During a conversation with a nursing home staff member, Barry learned that the nursing home sometimes granted overnight visitation.¹⁰⁰ He requested overnight visitation and was denied by the nursing home administration, who stated that the request could not be approved due to "the complex legal environment in which we exist."¹⁰¹ Barry was later in-

93. *See id.*

94. *See* Casta-Kaufteil, *supra* note 7, at 75-76.

95. *Id.* at 72.

96. Engber, *supra* note 48.

97. *Belinky v. Drake Ctr. Inc.*, 690 N.E.2d 1302, 1306 (Ohio Ct. App. 1996).

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

formed that the nursing home would not grant the request because they feared being sued if he were to molest his wife during an overnight visit and she were to later regain competence.¹⁰² Barry's daughters, mother-in-law, and family psychologist all wrote letters to the nursing home administration on Barry's behalf, informing them that Barry had no expectation of sexual intimacy from the overnight visits.¹⁰³ He merely wanted to comfort his wife at night.¹⁰⁴ Again, his request was denied.¹⁰⁵ The Ohio Court of Appeals ruled against Barry stating that "there is simply no concrete evidence that, given her complicated medical condition, Diane Belinky suffered any injury as a result of not having her husband spend the night with her once a week."¹⁰⁶

Sadly, the situation is often made worse by the family members of the individual with dementia. Like in the story of Bob and Dorothy, it is often difficult for an adult child to accept his or her parent or grandparent as a sexual being who craves intimacy.¹⁰⁷ These family members may be quick to sue a nursing home if they witness behavior that they believe to be inappropriate, offensive, or potentially harmful to their loved ones. Even if it is not in the best interests of the residents, nursing homes often will comply with the adult children's wishes because the children frequently are the ones who are paying the bills for the nursing homes.¹⁰⁸ These facilities fear that even if the situation does not rise to the level where an adult child chooses to litigate, he or she may choose to pull the resident from the facility and place the resident in another home that follows more conservative views on sexuality.¹⁰⁹

3. RATES OF SEXUALLY TRANSMITTED INFECTIONS

Additionally, legitimate concerns about sexually transmitted disease and infection rates exist among the elderly community, and

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Belinky v. Drake Ctr. Inc.*, No. C-980634, 1999 Ohio App. LEXIS 3110, at *7-8 (Ct. App. June 30, 1999).

107. See ALZHEIMER SCOTLAND, *supra* note 68, at 5 ("Relatives, especially grown-up children, may have difficulty in acknowledging that parents are sexually alive or feel resentment that a new partner appears to be taking the place of a parent who has died.").

108. Belonogoff, *supra* note 45.

109. *Id.*

these concerns require additional education and dialogue on the subject. Even the elderly are shy about discussing their sexuality¹¹⁰ and oftentimes will not initiate a dialogue with their physicians but instead will wait for their physicians to bring it up.¹¹¹ Unfortunately, this does not happen enough, and sexuality becomes a subject that is simply not discussed.¹¹² In one study, each of seventy older participants indicated that they had never been asked by a physician if he or she was sexually active.¹¹³

Many of today's nursing home residents grew up during an era in which an unplanned pregnancy was the primary worry associated with a sexual encounter.¹¹⁴ They came into their sexuality before the so-called safe-sex revolution and often are uneducated about the spread of sexually transmitted diseases.¹¹⁵ Many believe that because women are post-menopausal and thus unable to get pregnant, there is no need for contraceptive use.¹¹⁶ However, with the generally weaker immune systems of the elderly population, they may, as a group, be more prone to sexually transmitted infections.¹¹⁷ The rate of HIV and AIDS in the elderly community is on the rise.¹¹⁸ Currently, 13.4% of all reported incidents of AIDS are found in those fifty and older,¹¹⁹ but it is anticipated that by the year 2015, the majority of HIV carriers will be over fifty.¹²⁰ Elderly women may be particularly susceptible to HIV and AIDS because the vaginal lining, which becomes thinner and more fragile with age, can be torn more easily during intercourse, allowing dangerous pathogens to enter the bloodstream.¹²¹ Further, because some physicians wrongly assume that their senior patients are

110. Second World Assembly on Ageing, Madrid, Spain, Apr. 8–12, 2002, *HIV/AIDS and Older People*, U.N. DPI/2264 (Mar. 2002), available at <http://www.un.org/swaa2002/prkit/hivaids.htm>; Kristina Herrndobler, *Sex Medications Fuel HIV in the Elderly*, ENTERPRISE, Aug. 27, 2006, http://www.natap.org/2006/newsUpdates/090706_15.htm.

111. Deborah Kotz, *Sex Ed for Seniors: You Still Need Those Condoms*, U.S. NEWS & WORLD REP., Aug. 5, 2007, <http://health.usnews.com/usnews/health/articles/070805/13senior.htm>.

112. See Stan Grossfeld, *AIDS: A Threat to Elderly, Too Many Disregard Hazards of Unprotected Sex—Doctors Often Fail to Warn Them*, BOSTON GLOBE, June 4, 2001, at A1.

113. *Id.*

114. Belonogoff, *supra* note 45.

115. *See id.*

116. *See* Grossfeld, *supra* note 112, at A1.

117. Belonogoff, *supra* note 45.

118. Grossfeld, *supra* note 112, at A1.

119. *Id.*

120. Kotz, *supra* note 111.

121. *Id.*

not sexually active, the infection may go untreated for longer, resulting in unnecessary complications.¹²²

III. Analysis

A. Capacity to Consent to Sexual Activity

Courts and nursing homes generally differ in the ways in which they determine whether an individual has capacity. Courts vary by jurisdiction in the ways that they approach the subject of capacity determination, while nursing homes generally either adopt the Mini-Mental State Examination or employ a system of case-by-case evaluation.

1. THE JUDICIAL DETERMINATION

In a prosecution for rape, lack of consent can be found if a physical or mental disability “render[s] [the victim] incapable of knowing and intelligent consent.”¹²³ This kind of knowing and intelligent consent is unlikely in cases of individuals who suffer from moderate to severe dementia, which can make the individuals confused, forgetful, or unaware of their own behaviors and, therefore, unable to make rational decisions or provide clear consent to sexual activity.¹²⁴

There is no consensus regarding how to determine sexual consent capacity, and the criteria vary from jurisdiction to jurisdiction.¹²⁵ New Jersey requires only an understanding of the sexual nature of the act and that the act was voluntary, while some other states, including Arizona, Illinois, Indiana, Iowa, Kansas, and Louisiana, additionally require an understanding of the potential consequences of that sexual conduct.¹²⁶ Other states, including Alabama, Colorado, Hawaii, Idaho, New York, and New Mexico, impose yet another requirement: an understanding of the “moral quality” of the sexual conduct.¹²⁷ The morality standard requires that the individual be “mentally capable of understanding the social mores of sexual behavior.”¹²⁸ This means that the individual must understand not only the potential health con-

122. Belonogoff, *supra* note 45.

123. 75 C.J.S. *Rape* § 99 (2008).

124. See Engber, *supra* note 48.

125. Martin Lyden, *Assessment of Sexual Consent Capacity*, 25 *SEXUALITY & DISABILITY* 3, 5 (2007).

126. *Id.* at 6.

127. *Id.*

128. *Id.* at 5.

sequences of sexual behavior, like pregnancy or sexually transmitted diseases, but also the consequences imposed by society on sexual behavior that it deems immoral, such as social ostracism or stigmatization.¹²⁹ Due to the lack of uniform standards across the country, an individual could be deemed to have capacity in one state but not in another.¹³⁰

The two most common methods used by probate courts to determine the capacity of an individual are the clinical determination method and the judicial determination method.¹³¹ The clinical determination of competency “involves a psychiatrist, psychologist, or physician who is recognized by the court as qualified to make such determinations.”¹³² The judicial determination of competency is “based on evidence and expert testimony, where the capacity of a person to make decisions is made by a court.”¹³³

“Almost all courts adhere to the catechism that competency is not a unitary status”¹³⁴ Therefore, an individual may be found competent to engage in one activity but not another or be found competent at one time and not another.¹³⁵ This enables courts to consider the risks inherent in a particular activity, as well as the characteristics of the particular individual, when making a capacity determination.

For example, a patient with early dementia may not be able to render informed consent to an operation that has a significant risk of death but may be able to decide on what flavor of ice cream he would like for dessert. In most cases, the ability to consent to sexual activity could be considered to lie closer to the decision about ice cream than to decisions about major surgery.¹³⁶

129. *Id.* at 6; *see also* *People v. Easley*, 364 N.E.2d 1328, 1332 (N.Y. 1977).

An understanding of coitus encompasses more than a knowledge of its physiological nature. An appreciation of how it will be regarded in the framework of the societal environment and taboos to which a person will be exposed may be far more important. In that sense, the moral quality of the act is not to be ignored.

Easley, 364 N.E.2d at 1332 (citation omitted).

130. Lyden, *supra* note 125, at 7.

131. Elizabeth J. Reed, *Criminal Law and the Capacity of Mentally Retarded Persons to Consent to Sexual Activity*, 83 VA. L. REV. 799, 813 (1997).

132. *Id.*

133. *Id.*

134. Casta-Kaufteil, *supra* note 7, at 80 (quoting Michael L. Perlin, *Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?*, 20 N.Y.U. REV. L. & SOC. CHANGE 517, 542 (1993–94)).

135. *Id.*

136. *Id.* (quoting James P. Richardson, *Sexuality in the Nursing Home Patient*, 51 AM. FAM. PHYSICIAN 121, 123 (1995)).

2. THE NURSING HOME'S DETERMINATION

Because it is extremely rare that an individual with dementia will be brought before a court for a judicial determination of capacity, a nursing home staff often needs to make *ex ante* capacity determinations to establish which decisions the individual is capable of making on his or her own and for which decisions the individual lacks capacity.¹³⁷ Nursing homes generally use two different methods to determine the capacities of residents. More liberal institutions opt for capacity determination on a case-by-case basis whereas more conservative institutions use a standardized test called the Mini-Mental State Examination.¹³⁸

a. Case-by-Case Basis Some institutions evaluate residents' capacity to consent to sexual activity on a case-by-case basis.¹³⁹ Psychiatrists, psychologists, or social workers review each individual and the facts specific to his or her situation to come to a conclusion as to whether the individual is capable of consenting to or rejecting a sexual advance.¹⁴⁰ The psychiatrist, psychologist, or social worker can look to factors about the specific situation, such as whether the parties seek each other out, if they spend spare time together, if they engage in leisure activities together, and whether they forsake other potential partners, to determine whether the individual can consent to sexual behavior.¹⁴¹

b. The Mini-Mental State Examination The Mini-Mental State Examination (MMSE) is a standardized test of mental state that specifies a minimum score required to be able to consent to sexual activity.¹⁴² The MMSE is a brief questionnaire that is used to assess cognition.¹⁴³ The test generally takes only about ten to fifteen minutes¹⁴⁴ and ana-

137. Mayers & McBride, *supra* note 39, at 229.

138. See Engber, *supra* note 48.

139. *Id.*

140. *Id.*

141. INTER AGENCY GUIDELINES FOR LOTHIAN, MAKING CHOICES, KEEPING SAFE 53 (2004), http://www.mcks.scot.nhs.uk/resources/Making_Choices_April_2004.pdf.

142. Robert Perneczky et al., *Mapping Scores onto Stages: Mini-Mental State Examination and Clinical Dementia Rating*, 14 AM. J. GERIATRIC PSYCHIATRY 139, 140 (2006); see also Engber, *supra* note 48.

143. Perneczky et al., *supra* note 142, at 140.

144. *Id.*

lyzes several of the subject's cognitive functions, including memory, language, spatial ability, and set-shifting.¹⁴⁵ The test is based on a thirty-point scale, where a higher score indicates greater cognitive functioning.¹⁴⁶ A score of ten or below indicates severe dementia whereas eleven to twenty indicates moderate dementia; twenty-one to twenty-five indicates mild dementia.¹⁴⁷ A score of twenty-six to twenty-nine is inconclusive, and a score of thirty corresponds to normal cognitive functioning.¹⁴⁸

Because dementia is a degenerative disease, it is important that assessments of an individual's cognitive ability happen relatively consistently. One benefit of the MMSE is that the short time necessary to administer the test allows it to be used more frequently so that an individual's cognitive changes can be more easily tracked over time. However, this also means that in ten short minutes, a patient in an advanced stage of dementia can completely lose the right to any sexual intimacy, even with a spouse or long-term partner.¹⁴⁹ This is especially concerning as some research has called into question the MMSE's predictive value regarding incapacity.¹⁵⁰ One 2002 study of thirty-seven patients with mild to moderate Alzheimer's disease found that "the MMSE is not a very good predictor of incapacity."¹⁵¹ Additionally, the MMSE may over-diagnose cognitive deficits in individuals who have a limited educational history, have cultural differences, or suffer from depression.¹⁵²

145. Sabatino, *supra* note 25, at 492. The cognitive functioning is analyzed as follows:

memory (i.e., delayed recall of three items and response to questions related to temporal orientation); language (i.e., naming common objects, repeating a linguistically difficult phrase, following a three-step command, and writing a sentence); spatial ability (i.e., copying a two-dimensional figure); and set-shifting (i.e., performing serial sevens or spelling the word "world" backwards).

Id.

146. See Perneczky et al., *supra* note 142, at 140.

147. *Id.* at 141.

148. *Id.*

149. Engber, *supra* note 48.

150. Scott Y. H. Kim & Eric D. Caine, *Utility and Limits of the Mini Mental State Examination in Evaluating Consent Capacity in Alzheimer's Disease*, 53 PSYCHIATRIC SERVICES 1322, 1324 (2002), available at <http://psychservices.psychiatryonline.org/cgi/content/full/53/10/1322>.

151. *Id.*

152. See INJURIES AND DISORDERS IN THE ELDERLY, *supra* note 14, § 12.38; see also DSM-IV-TR, *supra* note 24, at 137.

Cultural and educational backgrounds should be taken into consideration in the evaluation of an individual's mental capacity. Individuals from certain backgrounds may not be familiar with the informa-

B. Proposed Solutions**1. LIMITED CAPACITY**

There has been some argument for the use of a “limited capacity” system where the individual’s capacity determination would depend on the risks inherent to the proposed relationship.¹⁵³ Most theories for determining capacity look at capacity as a black or white issue: an individual will be found either capable or not capable of consenting to the specific behavior at hand.¹⁵⁴ Alternatively, a limited capacity system acknowledges shades of gray.¹⁵⁵ Under a limited capacity system, an individual could be deemed to have capacity to consent to certain intimate behaviors but not to others or to have capacity to consent to a certain sexual partner but not to others.¹⁵⁶

Limited capacity does present practical issues in that enhanced enforcement is necessary for the system to function effectively.¹⁵⁷ Nursing home staff need to provide sufficient supervision and monitoring to ensure that individuals do not engage in behaviors that are outside of their recognized capacities.¹⁵⁸

2. GUARDIANSHIP

Another proposed solution is to give an individual’s guardian the right to consent on behalf of the individual with dementia.¹⁵⁹ According to the National Guardianship Association’s Standards of Practice, “[t]he guardian shall ensure that the ward has information about and access to accommodations necessary to permit sexual expression . . . to the extent the ward possesses the capacity to consent to the specific activity.”¹⁶⁰ However, this solution presents multiple potential problems. First, allowing anyone to consent to sexual activity on be-

tion used in certain tests of general knowledge (e.g., names of presidents, geographical knowledge), memory (e.g., date of birth in cultures that do not routinely celebrate birthdays), and orientation (e.g., sense of place and location may be conceptualized differently in some cultures).

DSM-IV-TR, *supra* note 24, at 137.

153. Lyden, *supra* note 125, at 17.

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. See Engber, *supra* note 48.

160. NAT’L GUARDIANSHIP ASS’N, INC., STANDARDS OF PRACTICE 7 (3d ed. 2007), <http://www.guardianship.org/pdf/standards.pdf>; Lyden, *supra* note 125, at 10.

half of another brings up significant worries of sexual exploitation, subjecting the individual to unwanted sexual activity. Conversely, the individual may be prevented from engaging in desired sexual activity. Because the guardian is often the individual's child, the child may disallow any type of sexual activity simply because children are not comfortable with the idea of their moms or dads being intimate.¹⁶¹

3. TRAINING AND EDUCATION

Many authors have advocated increased education and training for nursing home staffs, residents, and residents' family members.¹⁶² Education and training likely will foster increased understanding and acceptance for nursing home staffs and residents' family members, as well as build increased knowledge and safety for residents.

a. Nursing Home Staff Staff should be encouraged to act comfortably towards discussions of senior sexuality. The typical nursing home staff is predominantly nonprofessional and low-paid.¹⁶³ "The work is inherently hard and pay is low, the long-term care industry is beleaguered with poor publicity, and the individual or corporate owners are concerned about the bottom line financially."¹⁶⁴ The apathy or outright hostility that some staff members show towards elderly intimacy can lead to "pre-mature withdrawal of rights, under the unchallenged guise of 'lack of capacity.'"¹⁶⁵ "[S]taff should be guided by their duty to create an environment to help residents fulfill their needs and desires, while simultaneously maintaining their dignity and avoiding harm to others."¹⁶⁶ They must balance providing residents with an opportunity for privacy with protecting residents from potentially abusive situations.

Nursing homes should provide training to staff, specifically on how to handle issues of intimacy among residents. The purpose of such training should be to provide information and to desensitize staff to issues of elder sexuality, allowing the staff to become more com-

161. See Mayers & McBride, *supra* note 39, at 230.

162. *Id.* at 229.

163. *Id.*; see Casta-Kaufteil, *supra* note 7, at 74.

164. *Id.* (quoting Wood, *supra* note 12, at 792).

165. Casta-Kaufteil, *supra* note 7, at 75.

166. Hosam K. Kamel, *Facing the Challenges of Sexual Expression in the Nursing Home*, LONG TERM LINKS, Summer 2001, at 1, 4, available at <http://www.goodnewsconsulting.com/pdfs/pr7.pdf>.

fortable with handling issues as they arise.¹⁶⁷ Unfortunately, few nursing homes provide staff with education or training on the sexuality of residents.¹⁶⁸ In one study of thirty-three nursing home staff caretakers, only five indicated that a program existed to teach staff how to deal with sexual situations.¹⁶⁹

When educational programs are offered, staff members are generally very receptive, believing that such programs are valuable and help them to “feel more comfortable with sexual issues.”¹⁷⁰ In the previously mentioned study, twenty-seven of the thirty-three caretakers responded that they would like to participate in such a program.¹⁷¹ Education and training programs enable nursing home staff to become more knowledgeable on the issue of senior sexuality, and enhanced knowledge leads to an increased acceptance and tolerance of elders’ needs for sexual intimacy.¹⁷² Another study found that education for nursing home staff on geriatric sexuality “increased knowledge about sexuality in the elderly and resulted in more permissive staff attitudes.”¹⁷³ Despite the prevalence of dementia in the nursing home community, even the nursing homes that do offer such programs generally do not have training specific to the sexuality of residents with dementia.¹⁷⁴

Staff members also need to recognize that certain behaviors, which at first glance would appear to be sexual, may be explained by other causes. For example, a resident undressing in a common area could be explained by a number of nonsexual causes: he is too warm, the clothing is too restrictive, or he needs to use the bathroom.¹⁷⁵ Such behavior may be misinterpreted as inappropriately sexual.¹⁷⁶ Whatever the cause, be it sexual or otherwise, it is important for nursing home

167. See Mayers & McBride, *supra* note 39, at 230–31.

168. See Mayers, *supra* note 9, at 222.

169. *Id.* at 220, 222.

170. Mayers & McBride, *supra* note 39, at 228–29. This article presents the results of a pilot program to educate caretakers and administrators at a long-term care facility about the sexuality of geriatric residents. Participants were asked to complete a survey following the program about their reactions. The results indicated that all participants had a positive experience with the program, rating it, on average, 4.25 out of 5: 1 meaning the respondent did “not [like the program] at all” and 5 indicating that the respondent liked it “a lot.” *Id.*

171. Mayers, *supra* note 9, at 222.

172. See Mayers & McBride, *supra* note 39, at 230–31, 236.

173. Kamel, *supra* note 64, at 68.

174. Mayers & McBride, *supra* note 39, at 228.

175. Ballard, *supra* note 62, at 263.

176. *Id.*

staff to respond to resident behavior “calmly, with patience, gentleness, and understanding.”¹⁷⁷

b. Family Educating nursing home residents’ family members is a vital step in allowing family members to become more comfortable with their loved ones’ sexuality. Nursing homes should provide information sessions for the family members of residents to encourage them to understand and respect their loved ones’ continued need for intimacy. To foster acceptance of elder sexuality, it also is important for the family of the nursing home resident to recognize that their loved one had “lived with [her] sexuality for much longer than [she] ha[s] lived with dementia.”¹⁷⁸

c. Residents Educating residents will also play an integral role in the nursing home’s senior sexuality program. As explained previously, senior citizens often are uneducated about safe-sex practices and may be unintentionally and unnecessarily exposing themselves to danger when they engage in sexual behavior.¹⁷⁹ Studies have indicated that most of these residents are open to talking and learning about sexuality, if only someone would speak to them.¹⁸⁰ One study indicated that the majority of nursing home residents expressed “positive attitudes toward open discussion of sexual matters and willingness to accept therapeutic interventions when needed.”¹⁸¹ Because of the degenerative nature of dementia, however, there are many individuals for whom no amount of sexual education or training will make a sustainable change in their capacity assessments.¹⁸²

IV. Recommendation

To best serve the interests of nursing home residents, nursing homes should utilize a combination of increased training and educa-

177. *Id.* at 265.

178. ALZHEIMER SCOTLAND, *supra* note 68, at 6.

179. See Belonogoff, *supra* note 45; Grossfeld, *supra* note 112.

180. See Dov Aizenberg et al., *Attitudes Toward Sexuality Among Nursing Home Residents*, 20 *SEXUALITY & DISABILITY* 185, 188 (2002) (“Intimacy in institutions is a complex issue, but the [nursing home residents interviewed in the study] demonstrated an openness about discussing sexuality and willingness to receive help.”).

181. *Id.* at 185.

182. See DSM-IV-TR, *supra* note 24, at 141 (“The course of Dementia of the Alzheimer’s Type tends to be slowly progressive, with a loss of 3–4 points per year on a standard assessment instrument such as the Mini-Mental State Exam.”).

tion for nursing home staffs, residents, and residents' family members, as well as a system for limited capacity determinations.

As a first step, nursing homes should establish enhanced education and training programs. These programs will help build knowledge and acceptance of elder sexuality among nursing home staff and residents' family members, as well as provide more information to residents to promote resident safety. Because sexuality among individuals with dementia presents issues additional to those of the general elderly population, nursing homes also should provide education and training programs dealing specifically with issues pertaining to the sexuality of residents with dementia. These programs should be included along with the existing programs used in the training and education of nursing home staff.

As stated earlier, however, an education and training program will have little or no effect for certain residents with more severe cases of dementia. Therefore, while such a policy is important for many residents, it will not solve the problem completely. To further bridge this gap, nursing homes should consider utilizing a limited capacity method in their resident capacity evaluations.

As part of a limited capacity system, nursing homes should consider implementing a policy that provides a formal exception to the capacity to consent rules for those residents who have spouses or long-term sexual partners. To implement this policy, nursing homes should presume consent between those nursing home residents who have consented for years with the same sexual partner before losing cognitive functioning, even if the individual may not legally have the capacity to give it.

This exception would be similar to Federal Rule of Evidence 412(b), which provides that in a criminal prosecution for rape, the accused may introduce evidence of previous instances of sexual behavior between the alleged victim and the accused in order to prove consent.¹⁸³ The exception in Rule 412(b), however, is not available to an accused who allegedly has engaged in sexual behavior with a victim who lacks capacity.¹⁸⁴ For example, in a statutory rape case, the accused would not be able to introduce evidence that a nine-year-old victim consented in the past because the child would lack capacity and any previous consent to sexual intercourse would have been

183. FED. R. EVID. 412(b).

184. *United States v. Torres*, 937 F.2d 1469, 1473 (9th Cir. 1991).

invalid.¹⁸⁵ Many of the concerns that are present in cases of statutory rape, however, are not present in cases of sexual behavior among the elderly with dementia.¹⁸⁶ First, unlike in the case of statutory rape, the past consent of the involved individuals with dementia was previously valid before the point in time where the individual was found to lack capacity. Second, elderly individuals have more to gain and less to lose from sex than those below the age of consent.¹⁸⁷ Unlike those protected by statutory rape laws, elderly dementia sufferers who have been prevented from engaging in sexual behavior are not able to “look forward to a lifetime of fulfilling, consensual relations.”¹⁸⁸ Additionally, an elderly dementia sufferer’s risk of pregnancy or distress from an unwanted sexual advance is considerably less significant than the risks to their younger counterparts.¹⁸⁹

An individual with dementia’s condition may worsen if that individual is no longer allowed to engage in any intimacy with his or her long-term sexual partner because of a loss of cognitive functioning due to dementia. However, this presumption of consent may be rebutted. Nursing home staff must remain diligent in looking for behavior that would indicate a lack of consent, such as verbal or nonverbal signs of distress or one partner no longer recognizing the other partner. Staff must also watch for potentially dangerous sexual behaviors, like one partner engaging in, or attempting to engage in, sexual behavior with multiple partners.

V. Conclusion

When analyzing the issue of sexuality among nursing home residents with dementia, it is necessary to weigh the individual’s right to sexual expression against the individual’s need for safety and protection from abuse. Clearly, although shielding residents from abuse is important, nursing home staff should be careful not to take such protection too far. “It’s not too strong to say that when doctors are too quick to enforce celibacy as a way of protecting their patients from exploitative sex, they replace one form of elder abuse with another.”¹⁹⁰ As long as the risks associated with the sexual behavior can be suffi-

185. *See id.*

186. Engber, *supra* note 48.

187. *See id.*

188. *Id.*

189. *Id.*

190. *Id.*

ciently minimized, nursing home staff should strive to create an environment that is both safe and understanding of the individuals' needs for intimacy. This kind of environment will allow elderly individuals to enjoy the benefits of intimacy while mitigating as many of the risks as possible.