

Sexual Consent Capacity Assessment with Older Adults

Maggie L. Syme^{a,*}, Debora Steele^b

^aCenter on Aging, Kansas State University, Manhattan, KS 66502, USA

^bProvidence Care Mental Health Services, Lanark Leeds Grenville, Brockville, Canada ON K6V 5W7

*Corresponding author at: Center on Aging, Kansas State University, 1324 Lovers Lane, 253 Justin Hall, Manhattan, KS 66506, USA.

Tel.: 785-532-5945; fax: 785-532-5504.

E-mail address: msyme@k-state.edu (M.L. Syme).

Accepted 22 June 2016

Abstract

Many healthcare providers have a limited knowledge of sexual and intimate expression in later life, often due to attitudinal and informational limitations. Further, the likelihood of an older adult experiencing cognitive decline increases in a long-term care (LTC) setting, complicating the ability of the providers to know if the older adult can make his or her own sexual decisions, or has sexual consent capacity. Thus, the team is left to question if and how to support intimacy and/or sexuality among residents with intimacy needs. Psychologists working with LTC need to be aware and knowledgeable about sexual consent capacity in older adulthood to be prepared to conduct evaluations and participate in planning care. Limited research is available to consult for best practices in sexual consent capacity assessment; however, models of assessment have been developed based on the best available evidence, clinical judgment, and practice. Existing models will be discussed and an integrated model will be illustrated via a case study.

Keywords: Assessment; Sexual expression; Sexual consent; Capacity; Older adults; Long-term care

Sexual Consent Capacity Assessment with Older Adults

Psychologists working with older adults may be faced with the challenge of assessing sexual consent capacity, especially for those working for or within a nursing home setting. Ageist myths and stereotypes suggest that older adults are asexual (Hillman, 2012, pp. 18–24); however, research suggests that older adults remain interested and participate in various sexual and intimate activities across the lifespan and in various living settings, including nursing homes (Doll, 2013; Loue, 2005; Mahieu & Gastmans, 2015). Sexual and/or intimate expression within a nursing home setting is a complicated issue (Hajjar & Kamel, 2003), and becomes increasingly so given possible cognitive limitations and the potential impact that has on the older adult's sexual decision-making ability. Further, it is difficult for healthcare providers to determine if the older adult retains the ability to make sexual decisions given the lack of specific legal and clinical standards to guide the assessment and diagnostic process (Wilkins, 2015). Additional complications arise when the decision to support or prohibit intimacy is influenced—and potentially biased—by family and/or nursing home staff attitudes/fears. Within this context, the psychologist may be tasked with collecting the relevant “evidence” and collaborating with the team of providers and stakeholders (e.g., family) to make a clinical determination of the older adult's capacity to make sexual decisions.

Conceptual Definition

Sexual consent capacity is the ability to voluntarily make a reasoned decision whether or not to engage in sexual activities. This is distinct from other types of capacities in the following ways: (a) the nature of sexual relationships—within which these decisions are made—are often fluid and do not often develop in a logical way, (b) the decision is often made in the moment versus extended time to weight options, consult others, (c) substitute decision-makers or guardians are rarely, if ever,

appointed to an older adult specifically to make sexual decisions, and (d) it is one of the least-developed capacity domains in terms of assessment and diagnostic strategies (American Bar Association/American Psychological Association [ABA/APA], 2008; Kennedy & Niederbuhl, 2001; Lindsay, 2010).

Legal Standards

A legal definition of sexual consent across states generally involves three elements, with some exceptions by state (ABA/APA, 2008; Lyden, 2007; Tang, 2015). First, does the individual possess the “knowledge” needed to make the decision? This covers areas such as basic knowledge of sexual activities in question, illegal sexual activities, and appropriate times/places for sexual activities present. Second, does the individual demonstrate “voluntariness” or the ability to make a decision without undue influence or coercion (i.e., autonomy)? This may include the ability to take self-protective measures against coercion when making a sexual decision. Third, does the individual display a “reasoned understanding” or demonstrate an ability to take into account relevant knowledge (i.e., nature of the situation) and weigh the risks and benefits of engaging in it (i.e., appreciate the potential consequences)? There is a fourth criterion that is applied in nine states—appreciating the moral quality of the sexual activity in question. This is a controversial criterion, as its interpretation in the courts has been questioned due to the subjective nature of morality; however, this “highest threshold” criterion remains in place in some states (Tang, 2015). This highlights a further complication in interpreting legal standards for sexual consent, which is the variability in how courts apply the criterion to criminal proceedings not just across but within legal jurisdictions. Additionally, the majority of sexual consent cases to reference involve individuals with developmental disabilities. It is recommended that psychologists consult relevant state sexual consent law and any state nursing home legislation governing residents’ rights. For a more thorough discussion of the nuances in state laws and court interpretation, see Tang (2015). See also Lindsay (2010) for a discussion of nursing home care laws and statutes.

Ethical Considerations

Ethical factors are inherent in the assessment of sexual consent capacity and require continuous attention. The central issue is the tension between respecting and supporting the autonomy of the resident to engage in sexual and/or intimate activities of his/her choosing while protecting the resident (and other residents) from potential harm (Lichtenberg & Strezpek, 1990; Wilkins, 2015). Autonomy is often diminished among older adults who are directed by the decisions of family, guardians, and/or staff. Also, they may lack the opportunity and/or ability to advocate for their own wishes. This is particularly challenging in a nursing home environment where the sexual rights/autonomy of the resident may be overlooked in favor of eliminating any harm or potential problems (e.g., law suit, family issues, prohibitive staff attitudes) (Wilkins, 2015; Hajjar & Kamel, 2003).

Objectivity is key when considering harm reduction and autonomy, and the psychologist should remain attentive to the potential influences of each while not favoring either. For instance, to avoid the tendency to overemphasize harm prevention, it is imperative to hold individuals with dementia to the same standards for harm that we would any another individual. In other words, older adults have the right to choose to subject themselves to a “reasonable” amount of harm (Wilkins, 2015, p. 719). Achieving a balance requires a keen awareness of the potential imbalance away from autonomy in dependent care settings while fully assessing the potential risks and if those represent more than reasonable harm for the older adult.

Relevant Research

The research on sexual consent capacity among older adults is limited in quantity and direct application to the assessment process. There is a small body of legal research on sexual consent that outlines the federal, state, and case law relevant to sexual consent capacity among older adults, often lamenting the lack of specificity in law and the corresponding lack of specific clinical standards to assess sexual consent for older adults (Bartlett, 2010; Lindsay, 2010; Lyden, 2007; Tang, 2015, White, 2010). The legal literature consists mainly of conceptual reviews that provide recommendations for addressing older adult sexual consent legally and clinically, based on review of law and literature, experience, and professional judgment.

The majority of existing literature on sexual consent consists of conceptual reviews of sexuality and dementia or sexual expression within a long-term care (LTC) setting. These are often aimed at nursing professionals and/or healthcare teams within LTC and focused on practical care issues (Bauer, Fetherstonhaugh, Tarzia, Nay, & Beattie, 2014; Doll, 2013; Elias & Ryan, 2011; Hajjar & Kamel, 2003). A few of these articles provide suggested steps for care teams to take to address the challenges of sexual or intimate activities for residents with dementia. These are most often focused on nursing professionals and based on practical suggestions, clinical judgment, and ethical imperatives to protect residents from harm and support their

rights and needs for intimacy (Tabak & Shemesh-Kigli, 2006; Tarzia, Fetherstonhaugh, & Bauer, 2012). For instance, Everett (2008) outlines what she terms the “ethical perspective” on residents having sexual and intimate experiences. She suggests that the nursing staff address these four areas: (a) potential harm to self and participating other, (b) reasonableness of the risk involved, (c) capability (i.e., consent capacity), defined as an understanding of what the resident is engaging in and appreciating the consequences, and (d) weighing potential/reasonable harm to others (e.g., staff, family). She illustrates this with a hypothetical case and provides an ethical decision-making framework with additional questions addressing key areas of assessment to help guide team discussion. The ethical decision-making model suggested by Everett (2008) is designed to help support older adults who are found either mentally “capable or incapable” to express intimacy.

The empirical articles within the sexual expression in LTC literature address topics such as (a) establishing the existence and prevalence of sexual/intimate acts within LTC (Archibald, 2002; Doll, 2013), (b) assessing the barriers to sexual expression within LTC (Bouman, Arcelus, & Benbow, 2007; Villar, Celdran, Faba, & Serrat, 2014), (c) documenting the lack of sexuality training and policies within LTC (American Medical Directors Association, 2013; Lester, Kohen, Stefanacci, & Feuerman, 2016; Shuttleworth, Russell, Weerakoon, & Dune, 2010), and (d) describing older adult sexual abuse within LTC (Malmedal, Iversen, & Kilvik, 2015; Teaster & Roberto, 2004). While research on sexual expression within LTC may not provide evidence to inform specifics of assessment, it does provide context, and many of the factors described in the literature will need to be considered when making clinical recommendations. For example, psychologists should have an understanding of the barriers and supports for sexual expression inherent in the LTC setting, such as prohibitive staff attitudes about sexual expression and built environment limitations. This allows the psychologist to provide relevant, practical recommendations for team members (e.g., attitude awareness, adaptations to increase privacy).

Relevant medical and psychological research on sexual consent has documented the different ways in which cognitive decline affects sexual expression, which has direct implications for the assessment process. A major area of inquiry is hypersexuality or inappropriate sexual behavior (ISB) among individuals with dementia, which occurs in 7%–25% of these patients (Guay, 2008). Beyond prevalence, studies have also attempted to identify ISB patterns. In a review of ISB, Tsatali and colleagues (2010) cited a study of 165 patients with dementia showing that intimacy-seeking sexual behaviors (e.g., kissing, hugging) were associated with an Alzheimer’s disease diagnosis, whereas disinhibited sexual behaviors (e.g., exhibitionism, removing clothes in public spaces) were associated with other types of dementia. In a related study by Mendez and Shapira (2013), it was found that patients with behavioral variant frontotemporal dementia were the most likely to display hypersexual behaviors, though only 13% of a small sample ($N = 105$), underscoring the importance of executive function evaluation within the assessment.

Notable among the findings in the ISB research is that cognitive decline can have different effects on sexual interest/desire and behaviors. Some individuals with dementia display diminished sexual interest or apathy in early stages and some show increased interest and sexual disinhibition, possibly with sexually aggressive behavior. Interest in and frequency of sexual behaviors tends to decline in later stages of dementia, though this is not necessarily the case (Tsatali et al., 2010). Research on sexual activity among couples in which one partner has dementia may provide additional insight into these sexual patterns. This literature suggests sexual activity among couples with one intact partner and one partner with dementia tends to decline over time as impairment increases, in comparison to couples with both partners intact (Wright, 1998). Further, sexual activity tends to decline for multiple reasons that may not be directly due to cognitive decline. For instance, research has shown that caregiver’s physical health is a main reason for decline in sexual activity (Robinson & Davis, 2013). Thus, an individual with dementia may not necessarily have decreased interest/desire to engage in sexual or intimate activities, but may just need a willing/able partner. This may have implications for the assessment of sexual consent as an observed increase in sexual interest or behaviors in a newer resident with dementia may be due, at least in part, to finding a potential partner/resident who is willing and able, as opposed to the increase in interest and sexual expression being solely related to cognitive underpinnings. A sexual history may help to tease out if the interest/desire for sexual and intimate activities is new or existing.

Research on the assessment of sexual consent capacity has generated a few studies that are mainly focused on assessment of individuals with intellectual disability. One study examined experts’ evaluation of criteria necessary for sexual consent within this population (Kennedy & Niederbuhl, 2001), which included a factor analysis of items rated on the level of importance. Additional studies from Kennedy (1999, 2003) resulted in the development and testing of the Sexual Consent and Education Assessment (SCEA), a tool designed to help determine sexual consent capacity among individuals with intellectual disabilities. It consists of 12 knowledge (K-Scale) items and 5 skills (S-Scale) items, representative of the ability to understand the nature of sexual conduct, possible consequences of sexual activity, and the ability to exercise choice/resist coercion (see Kennedy, 2003 for full set of items). The SCEA has been shown—in a small sample of individuals with intellectual disabilities—to discriminate well among those deemed to have or not have sexual consent capacity by a team of healthcare professionals using similar criteria (Kennedy, 1999). In an additional study by Kennedy (2003), the SCEA was used to determine sexual consent capacity, results of which were compared to neuropsychological testing. Tests assessing executive functioning

skills (planning, problem-solving, utilizing environmental information, goal-directed behavior, and impulse control) memory, and instruction following were key in discerning true positives (96.1%) and true negatives (78.4%) as identified by the SCEA (Kennedy, 2003). These studies contend that the SCEA may extend to other cognitively impaired populations; however, the generalizability to older adults with dementia has yet to be tested, and may be limited (Bartlett, 2010).

When considering older adults, the research on assessment of sexual consent has yielded a smaller number of articles outlining clinical approaches to psychological and/or psychiatric assessment of consent (Hillman, 2016; Hillman 2012, pp. 102–106; Lichtenberg, 2014; Lichtenberg & Strzepek, 1990; Wilkins, 2015). Their recommendations are based on the best available evidence, including a review of the relevant issues, the authors' expertise in sexuality and dementia, and clinical judgment. To date, no empirical studies have been published that test these models on an older adult population, though they provide psychologists with much-needed guidance for addressing sexual consent.

Models of Assessment

Sexual Consent and Education Assessment

The SCEA is part of a model of sexual consent capacity assessment proposed by Kennedy (1999, 2003) and colleagues (Kennedy & Niehderbuhl, 2001) that was specifically designed for individuals with intellectual disabilities. It presents three areas integral to sexual consent assessment: (a) understanding the consequences of sexual activity, (b) having a basic understanding of sexual knowledge, and (c) possessing safety skills. The SCEA is the assessment tool associated with this model, which consists of 17 items outlining requisite sexual knowledge (K-Scale; 12 items) and safety skills (S-Scale; 5 items) for sexual consent capacity. Each item is stated as an ability, such as “Individual can differentiate between males and females” (knowledge) or “Individual can say or demonstrate no” (safety skills) (Kennedy, 2003). Knowledge items/abilities include understanding of sexual intercourse, masturbation, birth control, outcomes of sex, and ability to identify gender, genitalia, and other basic sexual knowledge. Safety skill items/abilities include effective personal safety practices, ability to communicate he/she does not want to engage in an activity, and ability to reject unwanted advances (see Kennedy, 2003 for full list of items). The format of the assessment is a clinical interview, and the clinician should ask various questions to determine if the individual possesses the knowledge or ability stated in the item. Questions to assess the abilities stated in the items are not provided in the assessment; however, in a formative study, Kennedy (1999) provided examples of the types of questions that can be used to elicit the specific abilities stated in the items, though she only provides these for two of the items.

Scoring instructions indicate that only those items “defined legally” are used to determine sexual consent capacity, which are all items on the S-Scale and two K-Scale items related to knowledge about sexual intercourse and identifying the major consequences of sexual activity (Kennedy, 1999, p. 23). The remaining knowledge items are used to inform recommendations for sex education. The author also recommends using additional neuropsychological tests—including tests for executive functioning and memory—to inform the results, as these cognitive abilities were found to discriminate well between people identified as having or not having sexual consent capacity according to the SCEA (Kennedy, 2003).

This model has some limited applicability to the psychologist assessing sexual consent among older adults. Some basic items/abilities described may be of use when creating a clinical interview; however, many of the items, such as those related to birth control and pregnancy, have little relevance to sexual consent among older adults. Adaptation of the SCEA items for an older adult population has potential to provide further guidance for the clinical interview process. For example, a small sample of gerontologists, neuropsychologists, and geropsychologists ($N = 128$) identified several items adapted for an older adult population as highly important to the sexual consent assessment process. Items rated most important assessed abilities such as voluntariness, understanding sexual expression, the ability to set limits and identify potential threats to safety (Syme, Lichtenberg, Moye, & Caalaman, 2015). This effort represents an initial step in the complex process of validating an adapted SCEA tool for use in sexual consent assessment with older adults.

Lichtenberg and Strzepek (1990)

The original, and foundational, model of sexual consent capacity assessment for older adults within the psychological literature was created by colleagues Peter Lichtenberg and Deborah Strzepek. They developed it as a clinical interview tool to use within their newly established co-ed Alzheimer's care unit. The model was built around key decisional abilities associated with making sexual decisions: choice, understanding of that choice, appreciation of the potential consequences, and the reasoning or rationale. Their assessment process begins with determining the cognitive impairment level of the resident via the Mini Mental State Examination (Folstein, Folstein, & McHugh, 1975) (MMSE), with those below a cutoff score of 14 are

suggested to be significantly impaired at a level that would question their capacity. The psychologist, preferably of the same sex, then conducts an interview assessing three main criteria. The first is awareness of the relationship, indicating the individual's choice and understanding of that choice. The second is the ability to avoid exploitation, which corresponds to reasoning. The third is an awareness of the potential risks involved in the relationship, which assesses the awareness of potential consequences and reasoning. This model suggests a team process, with input to corroborate, contradict, and/or add to the assessment findings. For a full description of the clinical interview, see [Lichtenberg and Strezepek \(1990\)](#) and [Lichtenberg \(2014\)](#).

Modification. No other assessment tools for sexual consent assessment for older adults have been developed since the original [Lichtenberg and Strezepek \(1990\)](#) model; however, additional guidelines have been suggested to modify the “original.” Of note, [Lichtenberg \(2014\)](#) provided additional contextual information to the original model, emphasizing the complex nature of consent and reminding clinicians that the sexual consent assessment is not the “ultimate determiner” of intimate relationships, but is a step in determining if the resident is able to maintain intimacy. Other key considerations for the clinician include the level of risk of the proposed intimate relationship, the potential to mitigate risk, and ultimately if the relationship can be supported regardless of the determination of capacity (i.e., limited capacity).

An additional modification was postulated in a theoretical paper on sexual consent. [Wilkins \(2015\)](#) reviewed different existing models for sexual consent capacity assessment—including the [Lichtenberg and Strezepek \(1990\)](#) model—and concluded that among the overlapping criteria, six emerged as necessary assessment components. The criteria included (a) voluntariness, (b) safety (protect from harm and recognize dangerous situations), (c) no exploitation (both avoid and respect others), (d) no abuse (physical or psychological to self or others), (e) the ability to communicate “no”, and (f) a sense of social appropriateness (a time and place for sex/intimacy) ([Wilkins, 2015](#), p. 719). He did not suggest a specific assessment tool or clinical interview strategy, but rather provided these conceptual criteria to guide an interview and team discussion. Similar to [Lichtenberg \(2014\)](#), the author suggests additional measures be taken to allow safe intimate expression when an older adult is found to be incapable of consent to sex by a formal evaluation (i.e., limited capacity). [Wilkins \(2015\)](#) suggests a “committee approach” wherein the healthcare team explores potential avenues for intimacy that can be expressed safely, thus balancing risk management with person-centeredness.

ABA/APA Model

The ABA/APA Handbook of Assessment of Older Adults with Diminished Capacity (2008) offers a multi-component model of sexual consent capacity assessment. As with other models, it is guided by the three major legal standards for sexual consent and suggests a team-based, clinical-interview approach that is supplemented through patient records, neuropsychological testing, and collateral information. Important areas of assessment include relevant medical, cognitive, social, and psychological history as well as the older adult's sexual values, considerations of potential risk, and the functional capacity assessment.

The functional capacity section covers the older adult's ability to understand and reason through sexual situations as well as voluntarily engage in sexual/intimate activities, recognizing the importance of choice for each person in the situation. While the ABA/APA model does not provide specific interview questions to assess functional capacity, it offers general guidelines based on legal standards and provides the original [Lichtenberg and Strezepek \(1990\)](#) model for further guidance.

This approach has considerable overlap with the original [Lichtenberg and Strezepek \(1990\)](#) model and subsequent modifications, which were primarily focused on the functional capacity assessment component. The ABA/APA model expands that to include components such as values, steps to enhance capacity, and a more comprehensive neuropsychological testing component (see [ABA/APA, 2008](#) for a full description and case illustration). As compared to other models, its primary focus is on the psychologist's assessment and gives few details about the subsequent team-based aspects of making a capacity determination and care plan.

Integrated Model

In a recent case study, [Hillman \(2016\)](#) illustrated an integrative model, combining several elements from the [ABA/APA \(2008\)](#) and original [Lichtenberg and Strezepek \(1990\)](#) models. This is perhaps the most detailed model of sexual consent assessment, in terms of the full assessment process. It discusses many of the contextual factors important to the assessment process (e.g., communication abilities, privacy, informed consent, team collaboration) and emphasizes several features and challenges inherent in sexual consent assessment with older adults (e.g., family involvement). With regard to the functional

capacity component, it is structured very similar to the APA/ABA and Lichtenberg and Strzepek models, and it is guided by the three major legal components of sexual consent (Lyden, 2007). Functional capacity assessment is embedded within a comprehensive clinical interview, cognitive assessment, records review, and interdisciplinary discussion that address limited capacity. Further, Hillman (2016) provides a comprehensive set of questions to guide the functional capacity assessment portion of the clinical interview and illustrates the model with two case examples.

Though other models for sexual expression management and sexual consent exist, they are not psychological or clinical assessment models and are not reviewed here. They are often based on ethical decision-making (see Everett, 2008), legal expertise (see Tang, 2015) or practical considerations for LTC settings (see Doll, 2012).

Clinical Recommendations

General Assessment Considerations

Collaboration and context are key considerations for the assessment approach. Models of sexual consent capacity assessment highlight the need for an evaluation by the psychologist combined with an interdisciplinary team process, involving the care team as well as a family representative, the older adult (when possible), and the ombudsman when needed (ABA/APA, 2008; Hillman, 2016; Lichtenberg & Strzepek, 1990; Loue, 2005). The team process is designed to be collaborative, with the psychologist consulting the team prior to the evaluation, presenting the evaluation results, and the team providing additional insights from multiple perspectives, including collateral information from the family.

An interdisciplinary team process is well established in nursing home settings, where the psychologist is likely to conduct sexual consent assessment. It is rare for sexual consent to be questioned when an older adult is living at home with a spouse or partner, as this affords more privacy/less oversight and is often dealt with informally. However, sexual abuse cases may arise concerning a caregiver and/or family member coercing an older adult into sexual situations in his or her own home. In this case, the psychologist should identify key individuals to consult who can provide collateral information.

For older adults, the diagnosis associated with questions of sexual consent is likely to be dementia. As with other types of capacity, psychologists should keep in mind that a dementia diagnosis is not a global indication of sexual consent incapacity, and that variation exists in symptoms and abilities for each older adult with dementia. Delirium, depression, other psychiatric disorders, and substance-induced dementia symptoms may also present with cognitive and functional limitations that may affect sexual decision-making, in some cases temporarily (ABA/APA, 2008).

In sexual consent capacity assessments, the psychologist should use a flexible, individualized approach (Lichtenberg, 2014; Wilkins, 2015). Sexual decision-making ability can fluctuate with time, environment, person(s), and activities involved. Thus, a universal, more rigidly followed approach does not serve the clinician well. For example, sexual consent capacity is not determined by a single, brief, and general instrument, such as the MMSE (Folstein et al., 1975). Research has shown the limited utility of the MMSE to determine capacity (Kim & Caine, 2002) and its use as a sole assessment tool is specifically cautioned in the ABA/APA Handbook (2008). It is recommended, instead, that the MMSE (and other such tools) be used as an initial screen for cognitive functioning, and additional neuropsychological testing—particularly tests more sensitive to executive dysfunction—be used in conjunction with the clinical interview (ABA/APA, 2008).

Sexual consent is not a dichotomous concept (yes or no), but is on a continuum that considers the relative risk/potential harm of the activity in question, the benefit to the resident(s), and the ability of the resident to consent or assent (Kuhn, 2002; Lichtenberg, 2014; Wilkins, 2015). This is consistent with limited capacity, which suggests that the resident may have capacity for some, but not all sexual and/or intimate activities (Lyden, 2007; White, 2010). To illustrate, the decision to engage in cuddling or kissing involves a low level of risk, whereas the decision to engage in intercourse has decidedly higher risk and potential for harm, especially when considering the relevant physical, cognitive, and emotional limitations of the older adult. The potential benefits to the resident are considered, and it is understood that intimate interactions that provide physical and psychological benefits for older adults and buffer against loneliness (Syme, 2014). Thus, it is suggested that even if the resident is deemed to lack capacity to consent to sexual intercourse through the formal assessment, steps should be taken by the team, a family representative (when available), and the resident (if possible) to determine if the intimate relationship in question is in the best interest of those involved. Further, the team should discuss ways in which potential harm can be mitigated while continuing to support the benefits of intimacy for the older adult (Everett, 2008; Hillman, 2016; Lichtenberg, 2014; Vancouver Coastal Health Authority, 2009; Wilkins, 2015).

Given these considerations, the following clinical approach is recommended for sexual consent capacity assessment. The approach represents an integration of the original Lichtenberg and Strzepek (1990) model with the ABA/APA Handbook for

Assessment of Older Adults with Diminished Capacity and subsequent suggested models (Hillman, 2016; Wilkins, 2015). Thus, it is based on consistent clinical recommendations in the assessment literature, constituting the best available evidence.

Recommended Assessment Approach

As mentioned, a well-established best practice for sexual consent capacity assessment is to embed the evaluation within an interdisciplinary team process. This includes a pre-evaluation consultation to determine the specific referral question and initially gather information from multiple perspectives. If the team has little experience with sexual consent capacity assessment, the psychologist can provide brief education in the following areas: (a) conceptual definition of sexual consent capacity, (b) the limits of cognitive screening tools in assessing consent, (c) how the information gathered in the assessment will be used, and (d) the concept of limited capacity and its implications for a care plan. The family and older adult(s) should also be involved to ensure that they are aware of and understand the assessment process (e.g., confidentiality of results, consent/assent to assessment, and potential outcomes of assessment) (Hillman, 2016). Any modifications for physical, emotional, or cognitive issues are explored as well (e.g., language/communication limitations).

Medical records review. When reviewing the medical record for relevant information, the psychologist should note conditions affecting sexual functioning (e.g., heart disease, diabetes, reproductive cancers, arthritis, pain, etc.), medications that may affect cognition and physical safety (e.g., those with sedating effects or known to cause confusion), and elements of functional status that could present risk when engaging in sexual expression (e.g., gait/ambulation).

Clinical interview. The clinical interview is a cornerstone of the sexual consent capacity assessment. Of note, if the older adult is not able to provide the requisite information, it is likely that the medical record review and/or collateral interviews may provide it. The interview includes several components, many of which are standard across assessment procedures (e.g., medical, psychological, and social history; functional status; basic behavioral observations). Additional areas to cover specific to sexual consent capacity may include a brief sexual and relationship history, specific behaviors related to the sexual activities in question, and an exploration of intimate and sexual values. Questions to assess sexual wishes or values include, “What are your wishes for an intimate relationship at this time?” or “What is important to you about your relationship with _____?”

The “functional capacity assessment” is a portion of the clinical interview aimed at assessing the three major legal areas of consent: knowledge/understanding, reasoning/capacity, and voluntariness/choice. Questions can be both hypothetical and/or specific to the current sexual situation. Here, the psychologist can utilize the original Lichtenberg and Strezepek (1990) model outlined earlier, with the three areas of assessment and corresponding questions covering understanding, reasoning, and voluntariness (see Lichtenberg, 2014). Also, Hillman (2016) provides several examples of functional capacity questions that map to each legal domain of sexual consent.

Collateral interviews. Similar information asked in the clinical interview is also gathered from several sources, including family members and/or legal guardians and interdisciplinary team members. Family members may provide information about medical, psychological, and social history, including past relationships and relationship values. Interdisciplinary team members give a much-needed perspective of the daily behavior of the resident. This can include reporting specific observations related to sexual and/or intimate behaviors, relationships on the unit, and other sexual and social history because the older adult has been in the home.

Neuropsychological testing. The interview process is supplemented with neuropsychological testing, which often begins with a cognitive screening tool (e.g., MMSE). A result that suggests impairment is further substantiated by administering more domain-specific tests (ABA/APA, 2008; Kim & Caine, 2002), the results of which provide additional insight into the ability of the individual to understand, reason, and provide voluntary assent/consent in a sexual and/or intimate situation. Corresponding cognitive abilities are delineated in the APA/ABA Handbook (2008): executive functioning (problem-solving, planning, and judgment), memory (semantic, episodic, and procedural), and attention. To illustrate, it is suggested that in order to display an “understanding” of sexual situations, the older adult needs attention and semantic memory for basic sexual information, episodic memory of previous sexual experiences, procedural memory for disease-prevention strategies, and executive functioning to understand the motives of a potential partner. For a fuller discussion of corresponding cognitive abilities, see the section on sexual consent capacity in the ABA/APA Handbook (2008).

Potential assessments to test each corresponding cognitive domain are as follows: (a) executive functioning—Trails B, Similarities and Judgment subscales (Cognistat), COWAT, (b) memory—Hopkins Verbal Learning Test-Revised (HVLTR), California Verbal Learning Test (CVLT), memory subscale of the Cognistat, and (c) attention—Digit Span (WAIS-IV), attention subscale (Cognistat) (ABA/APA, 2008; Hillman, 2012). These tests are not comprehensive recommendations, but are examples that complement, not eclipse, the results of the functional capacity assessment conducted within the clinical interview. In fact, decisions about which additional tests may be needed are guided by the deficits displayed within the functional capacity assessment and observations by others. For instance, if the older adult is found to have difficulties providing sufficient answers to interview questions related to reasoning through potential risks and benefits a sexual/intimate relationship, the psychologist may pursue further executive functioning tests. Together the results of the interview and testing present a more robust picture of the older adult's ability to understand the sexual/intimate situation, reason through the risks and benefits of engaging in sexual/intimate activities, and provide assent/consent.

Interdisciplinary discussion and action plan. When the evaluation is completed, the psychologist prepares the results of the interview and testing to discuss with the interdisciplinary team, which may include a preliminary set of recommendations. The team contributes any further evidence about the values, behaviors, and history of the older adult. Staff may provide key insights about the daily behaviors of the older adult, which can clarify questions about physical ability/functional status, indications of assent or coercion, and uncover potential harm to the older adult(s) (Hillman, 2016). The team discussion should also include a comprehensive evaluation of the potential risks and benefits of the proposed activities/relationship from multiple perspectives, which will assist in formulating an action plan, consistent with the level of assessed capacity. Notably, when considering input from additional sources (e.g., family, staff), it is important to remain aware of the potential advantages and disadvantages/biases from each source and to what extent the information can reliably inform the decision (Wilkins, 2015). For instance, family members likely know the older adult very well and may be able to communicate his or her wishes, but they also may struggle with their own discomfort with the older adult being sexual and these attitudes may cloud judgment.

A plan of action is subsequently formulated from the collaborative team discussion. The determination of capacity should include any recommendations to enhance capacity and strategies to support the proposed sexual/intimate relationship at an acceptable level of risk, consistent with a limited capacity approach (Lichtenberg, 2014). For example, the team may determine that the older adult does not have sexual consent capacity for intercourse, but determines the older adult is able to assent to intimate expression (e.g., cuddling, holding hands) with another older adult resident given the low amount of risk involved, the lack of harm observed in the relationship, and the benefits for the older adult(s). Team members may delegate responsibilities for an ongoing assessment of risk in the relationship, given the fluctuating nature of capacity.

The results of the full assessment process and the recommended plan moving forward should be discussed with the older adult, family and/or legal guardian. If needed, the ombudsman could be present to advocate for the older adult resident. As part of the discussion, the psychologist provides a summary of the functional capacity assessment, results of neuropsychological testing, and the recommendations from the formal evaluation so that any questions can be addressed at that time. The decisions of the team and action plan are documented in the care plan for the older adult and monitored for any needed changes.

Case Illustration

The following is based on a clinical case within a nursing home setting. However, additional, hypothetical details were integrated in consultation with a clinical provider from the healthcare team to illustrate the various components of the evaluation model proposed earlier.

Mrs. D, age 81 living with major neurocognitive disorder (NCD) of mixed etiology (Alzheimer's, vascular), was discovered in her LTC room with her blouse and bra removed. Sitting beside her on the bed was Mr. E., age 79 with major NCD (Alzheimer's). Due to concerns about harm, the couple was separated, and Mr. E was closely observed as he was initially thought to be the pursuer. Any interactions between the two were redirected; however, Mrs. D was found in similar situations, the care team noting she often pursued male residents for intimate contact. Mr. E did not continue to engage in any intimate activities and continued to be observed closely. Along with steps taken by the care team to ensure Mrs. D's safety, a referral to the team psychologist was made for her sexual consent capacity assessment.

The clinical interview revealed key information to understanding Mrs. D's pursuit of companionship. She was reportedly a "social butterfly," as described by staff and her daughter (Durable Power of Attorney; DPOA). Mrs. D reported she was married four times and when asked about her wishes for a relationship, she stated, "I like to be close with someone." Mrs. D's chart indicated, and her daughter reported, no history of or current mental health issues, which was consistent with her score on a brief depression inventory.

During “the functional capacity assessment”, Mrs. D was unable to identify an intended partner and showed limited understanding about the types of intimate activities in which she wanted to engage (“understanding”). When asked about her process of deciding to engage in a sexual/intimate activity, Mrs. D was able to say she liked to hold hands with a man and be kissed but was not able to demonstrate her decision-making process (e.g., the “why”) (“reasoning”). Notably, Mrs. D was able to identify that a person has a choice whether to participate in sexual/intimate activities; however, she was unable to communicate how to identify if someone did not want to engage intimately or what she would do if she did not want to engage in sexual activities (“voluntariness”).

A full neuropsychological battery had been completed on Mrs. D a few years prior, supporting her current diagnosis; however, the psychologist administered additional executive functioning (Trails B, Judgment subscale-Cognistat) and memory testing (Memory subscale-Cognistat) to briefly assess current functioning as it relates to making sexual decisions. Results were consistent with her existing diagnosis, suggesting that her memory and executive functioning remained significantly impaired.

The team convened to discuss the assessment results and additional behavioral observations. The psychologist indicated that the results of the evaluation suggest Mrs. D does not have the requisite understanding or reasoning about sexual activities and did not adequately demonstrate the ability to voluntarily engage in sexual activities, though she was able to say she did want intimacy and that she enjoys specific intimate activities. Consistent with a limited capacity approach, the team continued to discuss the results in terms of a risk–benefit analysis, noting that she may not have the capacity to engage in sexual activities but there may be ways to lessen any potential harm and still support intimacy. The recommendations given were to limit her sexual and intimate activities to those with lower potential for harm (e.g., touch, holding hands, and increased social interaction). Direct care staff noted that Mrs. D reacted very positively to nonsexual touch in their daily interactions, often extending a hand to hold or offering a hug. The team further discussed different strategies to increase nonsexual touch into Mrs. D’s care plan. The psychologist reinforced these options for enhancing her current capacity for intimacy and suggested a few strategies to manage the potential risks of Mrs. D pursuing sexual intimate behavior, such as additional observation to limit Mrs. D from taking other male residents to her room, redirection, and introducing new social activities.

The team formulated a proposed care plan and presented this to Mrs. D and her daughter in a care conference. Mrs. D’s daughter did not want her mother involved in any intimate relationship, but after discussing this with the team she understood that this was not a healthcare decision requiring consent from the DPOA. The psychologist further explained that her mother was being encouraged to fulfill her need for touch and intimacy in nonsexual ways, and that the team would continue to monitor, and amend the care plan to address any additional risk that may arise, as the team continues to support her needs for social interaction and touch. The team explored activities with the daughter and Mrs. D to fulfill her unmet needs for touch with manicures and back rubs; socialization by moving her to sit at a table with co-ed group, and social celebratory activities. As the care plan continued evolve, Mrs. D was noted to continue to pursue male companionship and developed a nonsexual friendship with another male resident and the team observed no further incidents.

Summary

Many older adults engage in sexual and intimate activities across the lifespan, including older adults living in LTC settings. This suggests healthcare providers will need to be prepared to attend to these situations, though they often report limited knowledge and attitudinal barriers (Hillman, 2012). The high incidence of cognitive decline among older adults in LTC presents a challenge to facilities when considering if older adults are capable of making sexual decisions. And, if not, how can intimacy be supported at an acceptable level of risk? A psychological assessment of sexual consent capacity can provide a solid basis for the team to determine these answers.

The integrated model of assessment presented can serve as a “roadmap” for psychologists in the assessment process, and it is also recommended to utilize the resources provided for further information in the area of sexual expression and consent and consult legal standards for sexual consent for your jurisdiction. It also requires a consultation with the administration within which the psychologist is situated. As noted, many facilities lack policies and procedures for sexual expression management and consent (AMDA, 2013; Lester et al., 2016); however, the psychologist will need to consult the local policies, if any, and may need to educate the administration and/or team about the process of sexual consent capacity, the possible outcomes of that assessment (e.g., concept of limited capacity), and the ways in which it can be utilized in the team process. Psychologists play a key role in helping the healthcare team determine the limits of sexual consent capacity and recommending concrete steps to manage risk while maintaining the benefits of intimacy for older residents.

Conflicts of Interest

None declared.

References

- American Bar Association/American Psychological Association (2008). *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists*. Washington, DC: American Bar Association/American Psychological Association.
- American Medical Directors Association (2013). *Elder care sex survey finds caregivers seeking more training*. http://www.amda.com/news/Bloomberg_infographic.pdf. (accessed September 13, 2015).
- Archibald, C. (2002). Sexuality and dementia in residential care—whose responsibility? *Sexual and Relationship Therapy*, 17 (3), 301–309. doi:10.1080/14681990220149103.
- Bartlett, P. (2010). Sex, dementia, capacity and care homes. *Liverpool Law Review*, 31 (2), 137–154. doi:10.1007/s10991-010-9077-6.
- Bauer, M., Fetherstonhaugh, D., Tarzia, L., Nay, R. & Beattie, E. (2014). Supporting residents' expression of sexuality: The initial construction of a sexuality assessment tool for residential aged care facilities. *BMC Geriatrics*, 14 (1), 82. doi:10.1186/1471-2318-14-82.
- Bouman, W. P., Arcelus, J. & Benbow, S. M. (2007). Nottingham study of sexuality and ageing (NoSSA II). Attitudes of care staff regarding sexuality and residents: A study in residential and nursing homes. *Sexual and Relationship Therapy*, 22 (1), 45–61.
- Doll, G. A. (2012). *Sexuality and Long-term Care: Understanding and Supporting the Needs of Older Adults*. United States: Health Professions Press.
- Doll, G. M. (2013). Sexuality in nursing homes: Practice and policy. *Journal of Gerontological Nursing*, 39 (7), 30–37. doi:10.3928/00989134-20130418-01.
- Elias, J. & Ryan, A. (2011). A review and commentary on the factors that influence expressions of sexuality by older people in care homes. *Journal of Clinical Nursing*, 20 (11–12), 1668–1676. doi:10.1111/j.1365-2702.2010.03409.x.
- Everett, B. (2008). Supporting sexual activity in long-term care. *Nursing Ethics*, 15 (1), 87–96. doi:10.1177/0969733007083937.
- Folstein, M. F., Folstein, S. E. & McHugh, P. R. (1975). 'Mini-mental state': A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12 (3), 189–198. doi:10.1016/0022-3956(75)90026-6.
- Guay, D. R. P. (2008). Inappropriate sexual behaviors in cognitively impaired older individuals. *The American Journal of Geriatric Pharmacotherapy*, 6 (5), 269–288.
- Hajjar, R. R. & Kamel, H. K. (2003). Sexuality in the nursing home, part 1: Attitudes and barriers to sexual expression. *Journal of the American Medical Directors Association*, 4 (3), 152–156. doi:10.1016/s1525-8610(04)70325-4.
- Hillman, J. (2012). *Sexuality and Aging: Clinical Perspectives*. New York: Springer.
- Hillman, J. (2016). Sexual consent capacity: Ethical issues and challenges in long-term care. *Clinical Gerontologist*. Advanced publication online.
- Kennedy, C. H. (1999). Assessing competency to consent to sexual activity in the cognitively impaired population. *Journal of Forensic Neuropsychology*, 1 (3), 17–33. doi:10.1300/j151v01n03_02.
- Kennedy, C. H. (2003). Legal and psychological implications in the assessment of sexual consent in the cognitively impaired population. *Assessment*, 10 (4), 352–358. doi:10.1177/1073191103258592.
- Kennedy, C. H. & Niederbuhl, J. (2001). Establishing criteria for sexual consent capacity. *American Journal on Mental Retardation*, 106 (6), 503. doi:10.1352/0895-8017(2001)106<0503:ecfsc>2.0.co;2.
- Kim, S. Y. H. & Caine, E. D. (2002). Utility and limits of the mini mental state examination in evaluating consent capacity in Alzheimer's disease. *Psychiatric Services*, 53 (10), 1322–1324. doi:10.1176/appi.ps.53.10.1322.
- Kuhn, D. (2002). Intimacy, sexuality, and residents with dementia. *Alzheimer's Care Quarterly*, 3 (2), 165–176.
- Lester, P. E., Kohen, I., Stefanacci, R. G. & Feuerman, M. (2016). Sex in nursing homes: A survey of nursing home policies governing resident sexual activity. *Journal of the American Medical Directors Association*, 17 (1), 71–74. doi:10.1016/j.jamda.2015.08.013.
- Lichtenberg, P. A. (2014). Sexuality and physical intimacy in long-term care. *Occupational Therapy In Health Care*, 28 (1), 42–50. doi:10.3109/07380577.2013.865858.
- Lichtenberg, P. A. & Strzepek, D. M. (1990). Assessments of institutionalized dementia patients' competencies to participate in intimate relationships. *The Gerontologist*, 30 (1), 117–120. doi:10.1093/geront/30.1.117.
- Lindsay, J. R. (2010). The need for more specific legislation in sexual consent capacity assessments for nursing home residents. *Journal of Legal Medicine*, 31 (3), 303–323.
- Loue, S. (2005). Intimacy and institutionalized cognitive impaired elderly. *Care Management Journals*, 6 (4), 185–190. doi:10.1891/cmaj.6.4.185.
- Lyden, M. (2007). Assessment of sexual consent capacity. *Sexuality and Disability*, 25 (1), 3–20. doi:10.1007/s11195-006-9028-2.
- Mahieu, L. & Gastmans, C. (2015). Older residents' perspectives on aged sexuality in institutionalized elderly care: A systematic literature review. *International Journal of Nursing Studies*, 52 (12), 1891–1905. doi:10.1016/j.ijnurstu.2015.07.007.
- Malmedal, W., Iversen, M. H. & Kilvik, A. (2015). Sexual abuse of older nursing home residents: A literature review. *Nursing Research and Practice*, 2015, 1–7. doi:10.1155/2015/902515.
- Mendez, M. F. & Shapira, J. S. (2013). Hypersexual behavior in frontotemporal dementia: A comparison with early-onset Alzheimer's disease. *Archives of Sexual Behavior*, 42 (3), 501–509. doi:10.1007/s10508-012-0042-4.
- Robinson, K. M. & Davis, S. J. (2013). Influence of cognitive decline on sexuality in individuals with dementia and their caregivers. *Journal of Gerontological Nursing*, 39 (11), 30–36.
- Shuttleworth, R., Russell, C., Weerakoon, P. & Dune, T. (2010). Sexuality in residential aged care: A survey of perceptions and policies in Australian nursing homes. *Sexuality and Disability*, 28 (3), 187–194. doi:10.1007/s11195-010-9164-6.
- Syme, M. L. (2014). Evolving concept of older adult sexual behavior and its benefits. *Generations*, 37 (4), 35–41.
- Syme, M. L., Lichtenberg, P., Moye, J. & Caalaman, E. (2015). *Sexuality and consent in long-term care: Assessment development through expert consensus*. Poster presented at the annual conference of the Gerontological Society of America, Orlando, FL.(2015, November).
- Tabak, N. & Shemesh-Kigli, R. (2006). Sexuality and Alzheimer's disease: Can the two go together? *Nursing Forum*, 41 (4), 158–166. doi:10.1111/j.1744-6198.2006.00054.x.
- Tang, S. L. (2015). When 'yes' might mean 'no': Standardizing state criteria to evaluate the capacity to consent to sexual activity for elderly with neurocognitive disorders. *The Elder Law Journal*, 22 (2), 449–490.
- Tarzia, L., Fetherstonhaugh, D. & Bauer, M. (2012). Dementia, sexuality and consent in residential aged care facilities. *Journal of Medical Ethics*, 38 (10), 609–613.

- Teaster, P. B. & Roberto, K. A. (2004). Sexual abuse of older adults: APS cases and outcomes. *The Gerontologist*, 44 (6), 788–796. doi:10.1093/geront/44.6.788.
- Tsatali, M. S., Tsolaki, M. N., Christodoulou, T. P. & Papaliagkas, V. T. (2010). The complex nature of inappropriate sexual behaviors in patients with dementia: Can we put it into a frame? *Sexuality and Disability*, 29 (2), 143–156. doi:10.1007/s11195-010-9187-z.
- Vancouver Coastal Health Authority. (2009). *Supporting sexual health and intimacy in care facilities*. Retrieved on February 11, 2016 from: https://www.vch.ca/media/FacilitiesLicensing_SupportingSexualHealthandIntimacyinCareFacilities2.pdf.
- Villar, F., Celdrán, M., Fabà, J. & Serrat, R. (2014). Barriers to sexual expression in residential aged care facilities (RACFs): Comparison of staff and residents' views. *Journal of Advanced Nursing*, 70 (11), 2518–2527. doi:10.1111/jan.12398.
- White, M. C. (2010). The eternal flame: Capacity to consent to sexual behavior among nursing home residents with dementia. *The Elder Law Journal*, 18 (1), 133–158.
- Wilkins, J. M. (2015). More than capacity: Alternatives for sexual decision making for individuals with dementia. *The Gerontologist*, 55 (5), 716–723. doi:10.1093/geront/gnv098.
- Wright, L. K. (1998). Affection and sexuality in the presence of Alzheimer's disease: A longitudinal study. *Sexuality and Disability*, 16 (3), 167–179. doi:10.1023/a:1023042924997.