Intimacy in the Elder Law Setting

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Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.[i]

Like Dylan Thomas' poetic exhortation to his dying father, America's baby boomers have no intention of going gently into the night. The first of the "official" baby boomers begins to collect Social Security this year.[ii] Not only is this the largest group of Americans, but their life expectancies and their health standards are such that their impact on American society has modified, and will continue to modify, standards in behavior and expectations for older Americans.[iii] As this generation ages, they are just as likely to shake up what we find, and expect to find, in our assisted living facilities (ALF) and nursing homes, as when they redefined much of America in their earlier lives. From youthful expectations during the Cold War to life on college campuses during the Age of Aquarius, to Me Generation consumerism, and onto issues involving politics, and now retirement, the baby boomers will shake things up and rage against the dying of the light.

Among the many aspects of American life the baby boomers impacted was sexuality. Their impact on sexuality is not likely to diminish as they go not-so-gently into the night. For us as attorneys, the question becomes what are the rights to intimacy of our older clients, especially when those rights are effected in their later

years by the potential for diminished mental capacity. The significance of this question will most likely manifest itself in the institutional settings of assisted living facilities and nursing homes. We are only beginning to see issues of sexuality in the institutional setting, and those institutions so far have often simply turned a blind eye to the tsunami of change and challenges they will inevitably face as their populations increasingly are composed of individuals from the baby boomer generation.

This paper is not intended to answer the questions surrounding intimacy, capacity and the rights of older clients, but rather simply to present issues and background. The answers, quite frankly, remain to be found by senior living facility administrators, elder law attorneys, the courts and American society in general. Nor is this paper intended to discuss obvious issues of sexual abuse, such as facility employees taking sexual advantage of residents in the facility. Rather, it is intended to discuss the legitimate sexual intimacy desires of residents and attempt to prod the reader into considering where the legitimate rights of residents merge into issues of capacity, privacy rights, and the moral judgments of others.

At initial blush (no pun intended) the issue of intimacy in an institutional setting is one of rights to privacy. While this may be logistically complex in situations where such privacy problems revolve around residents sharing semi-private rooms, those issues likely will be resolved as ALF's and nursing homes face demands for privacy so that residents may share intimate activities with their spouses or other chosen partners. A recent survey in the New England Journal of Medicine found that 26% of the population over 76 years of age reported being sexually active.[iv] It may be an issue the institutions would prefer not to face, but one they will deal with, progressively

or begrudgingly. But, where the question is not one of where to find privacy for intimacy, but of the nature of the capacity to demand and enjoy intimacy, that will complicate policies for institutional senior living facilities.

Of the approximately 76 million people comprising the baby boomer generation, it is estimated that approximately 10 million will develop Alzheimer's Disease.[v] This figure represents a doubling of the current level of Alzheimer's Disease patients in the population.[vi] Alzheimer's Disease is simply the best known form of dementia, making up 60 to 80 percent of dementia cases. Other, less well known to the public, forms of dementia will effect the cognitive ability of millions more of our senior citizens. Significantly, some of these other dementia forms, such as Dementia with Lewy Bodies and Frontotemporal Dementia, leave the individual with significant changes in their behavioral patterns, often including decreases in conformity to social norms and increases in sexual desires.[vii] The result of this is, rather than the long assumed decrease in sexual interests and desires, at least a portion of the elderly population will actually have an increased libido, sometimes combined with a decrease in social inhibitions.[viii] This portion of the dementia population may be in the neighborhood of 16 percent.[ix] What is often seen as "acting out" in senior living facility residents, or anti-social behavior, is sometimes the result of their dementia instead. Dealing with these issues presents a challenge for elder law attorneys, who often deal with not just purely legal issues, but social and familial issues as well.

The right to sexual intimacy is at its core a right to privacy issue. While we place restrictions on the rights of minors to sexual intimacy, the right to sexual

intimacy in competent adults is presumed in today's society. Many states have left their fornication, sodomy, and other similar statutes in their criminal codes. However, state and federal case law has essentially abandoned any attempt to control or regulate the private sexual activities of competent, consenting, adults on due process grounds, thereby relegating such sexually oriented statutes to the status of "blue laws.".[x]

> This, as a general rule, should counsel against attempts by the State, or a court, to define the meaning of the relationship or to set its boundaries absent injury to a person or abuse of an institution the law protects. It suffices for us to acknowledge that adults may choose to enter upon this relationship in the confines of their homes and their own private lives and still retain their dignity as free persons. When sexuality finds overt expression in intimate conduct with another person, the conduct can be but one element in a personal bond that is more enduring. [xi]

As a result, the issue of the right to sexual intimacy in the institutional residency setting is essentially a logistical one, rather than a legal issue. But, this in no way eliminates the many and varied issues remaining concerning what constitutes consent and how issues of competency enter into this discussion.

"Consent" as defined in Black's Law Dictionary, is governed by "voluntary agreement by a person in the possession and exercise of sufficient mental capacity to make an intelligent choice to do something proposed by another."[xii] In the context of sexual intimacy, consent is normally defined in juxtaposition to lack of consent, resulting in rape or other forms of sexual abuse or misconduct. Lack of capacity to consent is seen as non-consent and therefore a criminal act.[xiii] From here, the subject can quickly become quite complex. Colorado's Unlawful Sexual Behavior statutes (§§ 18-3-401 et seq, Colorado Revised Statutes), for example, include in the definition of "consent" that "A current or previous relationship shall not be sufficient to constitute consent under the provisions of this part 4."[xiv] This language was

undoubtedly intended to deal with non-consensual sexual relations between married persons or those with an on-going interpersonal relationship where both have capacity, and to eliminate the historical marital privilege under which a husband by definition could not rape his wife. However, it would not be unreasonable to believe that a zealous prosecutor might interpret this statement such that a person now lacking mental capacity, yet married to an individual for a lengthy period of time, could not consent to sexual intimacy with his or her spouse even though they be participating in sexual activities which had been the norm in their marital relationship for the entire length of the marriage. The substantive criminal code sections that follow specifically define "sexual assault" to include that the "actor knows that the victim is incapable of appraising the nature of the victim's conduct;"[xv] Similarly, Alabama's criminal code uses essentially identical language to define "mentally defective" with regards to the ability to consent to sexual activity.[xvi] Many other state's statutes track this language, which stems from the Model Penal Code.[xvii]

How does one interpret these statutes in light of the fact that mental capacity is not a light switch? The issue is not a bright line, black or white, test of whether an individual has capacity or does not have capacity to form consent. Under the uniform law on guardianship and protective proceedings, the modern trend is to recognize that mental capacity is a continuum on which an individual may have the ability to conduct certain activities while lacking capacity to evaluate and interpret other actions.[xviii] Under the standards of this uniform act, an adjudication of incapacity is not sufficient to relieve the individual of all of their decisional capacity or privilege. Even the judicial determination of the need for a guardian is not a finding that the individual lacks

mental capacity in all activities, and thereby may fail the threshold set by criminal law statutes concerning the ability to consent to sexual intimacy.

Complicating the issue is the practical reality of how courts are issuing their guardianship orders, even in states which have adopted the Uniform Guardianship and Protective Proceedings Act (UGPPA). In non-UGPPA states the order granting guardianship is typically an all encompassing order granting the guardian all the powers set forth in that state's guardianship statute. Even in states which have adopted UGPPA, though the statute calls for a detailed description of the authorities of the guardian, and limitation of the authorities of the guardian to necessary functions to protect the protected person, the typical order does not do this.[xix] Assuming the statute is followed in spirit, the typical state law powers of a guardian don't come close to delineating the authority of the guardian, or the rights of the individual, with regard to sexual intimacy. Attempting to obtain determination by a court of the ability of an individual with diminished mental capacity to participate in sexual intimacy, or of the rights of that individual regarding their desire for sexual intimacy, is difficult at best, and a path likely to cause significant reluctance by the court to act.

The issue of right to sexual intimacy of an individual with diminished mental capacity is a difficult one under the best of circumstances, even where the individual has been declared legally incapacitated. Even more difficult is the question of the rights of an individual where there has never been a determination of incapacity. Where the individual, recognizing their impending incapacity, or simply through thoughtful estate planning, has executed medical and financial durable powers of attorney during a time when the individual held capacity, no judicial determination of

incapacity would normally exist. One of the primary advantages of execution of powers of attorney is the avoidance of the need for guardianship or conservatorship proceedings, and their inherent intrusion by the court in the private affairs of the individual. Without a judicial determination of incapacity, the rights of the individual are preserved, including the right to participate in sexual intimacy.

Even in situations where the parties who have special concern and care for the individual recognize the individual has diminished capacity, it is not likely even the most liberal interpretations of the rights of an agent under power of attorney would include the power to determine the right of the individual to participate in sexual intimacy. In any event, without a determination that the individual lacks mental capacity to make his or her own decisions, the agent would not have the ability to override the decisions and desires of the principal. General powers of attorney are designed to permit the agent to conduct business and financial activities on behalf of the principal. Nothing in a typical authorizing statute for a general power of attorney would permit the agent to make decisions concerning sexual intimacy. As agent under medical power of attorney no such authorities would appear to exist either. Medical power of attorney statutes generally authorize the agent to make decisions concerning medical care. While sex is a physical act, its strains credibility to consider sexual intimacy as medical treatment.[xx] In any event, agents under power of attorney are fiduciaries who must exercise their authority in conformity to the wishes of the principal, and not their personal moral beliefs concerning the conduct of the principal.[xxi]

The decision in Lawrence and other cases, combined with traditional

reluctance of courts to enter into issues of consensual sexual activities by adults, leaves us with little statutory or case law to guide us through the issues which will be increasingly presented to ALFs and nursing homes regarding the rights of their residents to sexual intimacy. Compounding the question is the reality that there is no single set of facts and circumstances which define the question of the rights to sexual intimacy of individuals with diminished capacity.

Superimposed upon the rights of individuals with diminished capacity to sexual intimacy is the moral judgment placed upon such activities by other actors in the life of the individual with diminished capacity. While often the objectors to such activities are the institutional administrators and employees, they are not alone. Quite often it is the adult children of the individual who object to mom or dad's participation in sexual activities, for a variety of reasons. It may be objection to the parent having sexual intimacy with someone other than the other parent of the adult child. It may be the personal moral or religious values of the adult child which run against the grain of such activities. Or, it may simply be the classic case of the adult child not wanting to have to contemplate sexual activity in their elderly parent. In American society it is almost impossible to discuss the subject of sexual intimacy without the imposition of personal moral values. In the case of sexual intimacy among elderly persons, especially elderly persons with diminished capacity, this is even more true.

A look at representative cases presented to elder law attorneys reflects the problematic issues which routinely present themselves concerning sexual intimacy. The following case studies, presented by elder law attorneys who deal with such issues as a part of their practice, reflect a representative sample of the multi-faceted

questions which must be contemplated to deal with sexual intimacy among persons with diminished capacity. (Note: While these case studies are based upon actual cases, careful steps have been taken to mask the identity of the individuals involved and the identity of the attorneys involved.)

Case 1

Mr. A, a 78 year old, widowed male, suffers from mild dementia, and lives in an assisted living facility. Physically healthy, he has a strong sex drive and wishes to maintain an active sex life. To this end, he often attempts to find female companionship, and has a doctor friend who provides him a prescription for Viagra. For a variety of reasons the only physical companionship he obtains is through the use of professional “escorts.” Mr. A’s son, his conservator, does not approve of his father’s behavior and to that end attempts to restrict Mr. A’s access to financial resources with which to pay for the services of the escorts. Mr. A has significant financial resources and the conservatorship orders permit Mr. A a sizeable cash allowance for discretionary spending. Mr. A’s son has come to you wanting to know what can be done to restrict his father’s behavior.

Case 2

Mrs B, a widowed 80 year old, has mild dementia and lives in an assisted living facility. She is quite physically active and has few inhibitions. She is charming and outgoing. She also has a strong sex drive. She is quite popular in the assisted living facility with the single male residents, and some of the married male residents as

well, as it is Mrs. B's behavioral pattern to engage male residents in sexual intimacy on a short term basis, then she "moves on" to the next male. She makes it a habit to meet the new male residents, who then are added to her growing list of conquests. While it is possible that her dementia may be decreasing her social inhibitions, in fact this behavior is part of a life long pattern of promiscuity. Her adult daughters do not approve of their mother's promiscuity, and never have. They have used their power of attorney to move Mrs. B from one assisted living facility to another in an attempt to restrict her social contacts. As might be expected, just the opposite has occurred. Mrs. B sees nothing wrong with serial, short term, sexually intimate relationships. You have been appointed by the court as her guardian ad litem.

Case 3

Mr. C is a single male in his late 70s, living in an assisted living facility. He suffers frontotemporal dementia, resulting in decreased behavioral inhibitions and increased sexual desires. Unfortunately, his illness has also decreased his interpersonal social skills and inhibitions. He has been forced out of a number of facilities due to his unfortunate habit of attempting to develop interpersonal relationships by socializing with female residents of the facility and in quite short order asking them if they would like to come to his room to watch pornographic videos from his rather extensive collection. More recently, Mr. C has begun to see the nursing staff of the facility as desirable companions for his physical affections and has on more than one occasion been accused of groping the breasts and buttocks of female employees. You have been appointed by the court as counsel for Mr. C, who has

again received notice of intent to remove him from the facility.

Case 4

Mr. and Mrs. D are a couple, married for over 40 years. Mrs. D suffers moderate dementia and as a result lives in a nursing home. Mr. D is declining physically, but could live in an assisted living facility. By his preference, he lives with Mrs. D in a suite at the nursing home. Mr. And Mrs. D are sexually active, however the medical staff at the nursing home has expressed concerns about Mrs. D's ability to consent to such activity. On a recent occasion a member of the facility staff entered the suite of the D's and observed Mr. and Mrs. D engaged in sexual relations which involved sadomasochistic activity. Upon investigation it was learned from Mr. D that this was a life-long lifestyle of Mr. and Mrs. D. When questioned, Mrs. D told the investigator that she enjoyed such activities and considered it none of the investigator's business. You have been appointed as guardian ad litem by the court.

Case 5

Mr. E is a single, 84 year old male, living in an assisted living facility. In all aspects he appears to be a model resident. However, he spends a great deal of his time viewing pornographic material and masturbating. He only participates in these activities in the privacy of his own, single room. However, because of the frequency of his activities, on multiple occasions members of the staff have entered into his room and interrupted him during the course of his activities. You have been retained by the facility to determine a proper course of action to bring about Mr. E's removal from the

facility.

Case 6

Mr. F is a married male, in his late 70's, living in nursing home due to his Alzheimer's Disease. His wife is in her late 60s and continues to live in the community. Mr. F does not recognize his wife when she comes to visit him, though sometimes he believes she is his adult daughter. Mr. F has recently become romantically interested in Mrs. G, a widowed female resident who lives down the hall from Mr. F. Mrs. G suffers from Alzheimer's Disease as well. Initially, the staff found their relationship "cute." As the relationship has developed, Mr. F and Mrs. G have begun to exhibit signs that they may be sexually active with each other. Upon examination, Mrs. G. Indicated to her doctor that she enjoyed having her husband back again from the war, as they are very much in love with each other. Mrs. F is aware of the situation. While she finds it sad that her husband suffers dementia, she is pleased that he has found companionship, understanding that he does not comprehend that she is really his wife. She is not upset with the romantic, and possibly intimate, relationship that is developing between her husband and Mrs. G. Mrs. G's adult children do not share her feelings on the subject.
You have been asked by the facility to act as a mediator in this situation.

Case 7

Mr. H is a single male with moderate dementia, living in an assisted living facility who has recently become involved with Mrs. J. A widow who has for many years

come to the facility to act interact with residents for enhancement of their lifestyle, and leading group activities at the facility. She is a volunteer from a local community service group. Mr. H and Mrs. J have begun to be romantically involved and spend a good deal of their evenings in Mr. H's private room, where the staff believes they are engaged in sexual activities. The facility has contacted you as they have never had a policy on sexual relations of their residents, either with each other or with individuals who are not residents of the facility.

Case 8

Mr. K is a single individual with moderate dementia. He lives in the assisted living facility. He has a brother in a distant city who is his agent under financial and medical powers of attorney. He has strong sexual desires and frequently leaves the facility to seek companionship in the local environs of the large city in which the facility is located. He frequents the bars in town but has difficulty finding companionship. Recently, his journeys in search of physical companionship have led him to some of the less desirable areas of town. On one occasion he was the victim of a mugging by friends of a prostitute who picked him up and took him into an alley behind the bar. On more than one occasion he has engaged the services of one of the local transsexual prostitutes. In discussion of this with a counselor at the facility, it was learned he does not understand this individual is really a street prostitute interested in his money. He believes the prostitute is a female, in love with him and who enjoys his physical company. The prostitute has begun to come to the facility to visit Mr. K in his room. After the visits, Mr. K has complained of items being missing from his

room, but does not associate this with the prostitute's visits. You have been appointed by the court as guardian ad litem, after the facility sought guardianship proceedings.

Case 9

Mr. L suffers moderate dementia, and lives in an assisted living facility. He has no living relatives, other than a daughter-in-law, Ms M, who is a social worker. Mr. L has a strong sex drive, but lacks the mobility to find social companionship outside of the facility. Ms M has recently begun to bring her "aunt" to the facility with her for visits to Mr. L. Oddly, shortly after they arrive for the visits, Ms M normally leaves the private room of Mr. L, though the aunt always remains with him. Ms M sometimes leaves the facility entirely, or hangs around the break room at the facility. After a certain amount of time, Ms M's aunt exits Mr. L's room, reconnecting with Ms M, who then goes to say a brief goodbye to her father-in-law before she and the aunt leave the facility. A staff administrator has come to you and presented these facts, asking for advice and expressing her suspicions about the aunt. No one, resident or staff, at the facility has expressed an objection to what is happening, although Ms M, her aunt and Mr. L have increasingly been the subject of gossip between staff members and also among the residents of the facility.

Case 10

Mr. and Mrs. N are a married couple, both of whom live in a local nursing home. Mrs. N suffers moderate dementia, and some have begun to question whether she

really understands that Mr. N is her husband. Based on nursing home policy, though they are married they live in separate rooms, he on the all male wing of the facility and she on the all female wing. While they live separately in the facility, they do see each other and spend time together daily. The staff have noticed that they seem to disappear from sight on a regular basis each week. On at least one occasion a staff member found them engaged in sexual activities in an empty room in the facility. They have been warned informally by staff that the facility does not permit sexual activity among its residents. As a result, Mr. N has retained you to advise him.

Each of this cases illustrate the difficulties involved in determining a reasonable and proper course of action. Neither attitudes of moral outrage or laissez-faire in-action will suffice. Yet, at the same time there is no inherently “correct” course of action either. As attorneys, and as a society, we have begun the path into essentially uncharted territory. This territory is fraught with legal implications, moral dilemmas, and potential changes in social attitudes.

The baby boomers are beginning to make the transition from the dominant group in the work force to the dominant group in retirement. As they continue to age, they will become the dominant force in the assisted living and nursing home facilities as well. We, as attorneys concerned with our aging clients, must now begin to address the legal, moral and philosophical questions concerning intimacy in this group. The solutions will not come easily.

Endnotes

i. “Do Not Go Gently Into That Good Night”, The Poems of Dylan Thomas, 1952, New Directions Publishing Corp.

ii. Baby boomers are defined as those born between 1946 and 1964. The first baby boomer signed up to collect Social Security in 2007. Born January 1, 1946, she is defined as the “first baby boomer.” Butricia, Barbara A., Howard M. Iams, and Karen E. Smith, Its All Relative: Understanding the Retirement Prospects of Baby Boomers, The Urban Institute, 2003

iii. Ibid p. 3

iv. Lindau, S., Schumm, P., Laumann, E., Levinson, W., O’Muircheartaigh, C., and Waite, L., “A Study of Sexuality and Health Among Older Adults in the United States,” (2007) 357 *New England Journal of Medicine*, 762-774

v. 2008 Alzheimer’s Disease Facts and Figures, Chicago, IL, The Alzheimer’s Association, 2008.

vi. Ibid. P. 9

vii. Ibid, pp. 5, 6.

viii. Deacon, S., Minichiello, V., and Plummer, D., (1995) *Sexuality and Older People: Revisiting the Assumptions*, Educational Gerontology, 21, 497-513

ix. Cummings, J. and Victoroff, J., (1990) Noncognitive neuropsychiatric syndromes in Alzheimer's disease. Neuropsychiatry, Neuropsychology, and Behavioral Neurology, 3, 140-158.

x. Lawrence v. Texas, 539 U.S. 558 (2003), essentially struck down laws against private, consensual homosexual acts, and reversed Bowers v. Hardwick, 478, U.S. 186 (1986). See also Eisenstadt v. Baird, 435 U.S. 438 (1972) regarding the fundamental nature of the right to freedom from governmental interference in fundamental issues of procreation.

xi. Lawrence v. Texas, 539 U.S. 558 (2003) at 567.

xii. Black’s Law Dictionary, 6th ed., 1990, St. Paul MN, West Publishing Co., p. 305.

xiii. The various states use a variety of terms to define non-consensual, and therefore criminal, sexual activities, ranging from the more traditional terms “rape” and “statutory rape” to “sexual abuse” and “sexual misconduct.” Nothing in the use of these terms in this paper is meant to be confined to the various state criminal code definitions of these terms. The reader should use a layman’s definition of such terms and not attempt to parse these terms. It is beyond the scope of this paper to delineate when sexual conduct becomes criminal.

xiv. § 18-3-401(1.5), C.R.S.

xv. § 18-3-402(1)(b), C.R.S.

xvi. § 13A-6-60(5) and § 13A-6-61(a)(2), Code of Alabama

xvii. § 213.1(2)(b), Model Penal Code

xviii. Uniform Guardianship and Protective Proceedings Act, National Conference of Commissioners on Uniform State Laws, 1997, Prefatory Note

xix. See, for example, § 15-14-314, Colorado Revised Statutes.

xx. See for example § 15-14-506, Colorado Revised Statutes, authorizing the agent under medical power of attorney to "act on behalf of the individual in consenting to or refusing medical treatment."

xxi. § 15-14-508(2), Colorado Revised Statutes