



## Dementia Does Not Remove Sexual Desire — But Changes How It Appears



One of the most avoided subjects in dementia care is not continence, aggression, or even end-of-life decline. It is sexuality.

Not the sanitised version of it. Not the softer language of “companionship” alone. Sexuality.

Because the moment dementia enters the room, many people quietly behave as though sexual desire should leave with it.

But dementia does not automatically remove sexual desire. It changes the brain’s ability to regulate, interpret, and express it. That is a different statement altogether, and one with very different consequences for families, partners, and care settings. Research and clinical review literature describe dementia-related changes in sexual behaviour as complex and variable, not absent by default. Some people become less interested in sex. Some retain desire but lose confidence, timing, language, or inhibition. Some become more overt, more impulsive, or less socially filtered. In frontotemporal syndromes in particular, damage to frontal and temporal networks can distort reward-seeking and behavioural control in ways that affect sexual expression.

That difference matters, because families and services often misread the whole picture.

If desire is assumed to be gone, then any later sexual expression is treated as pathology. If every sign of closeness is called “just connection,” then sexual desire is explained away. If every act of sexual expression is called “challenging behaviour,” then the person is reduced to risk. All three responses are failures of interpretation.

The more accurate question is not, “Why is this happening when they have dementia?” The more accurate question is, “What part of sexuality remains, what part of regulation has changed, and what is this person actually communicating now?”

That is where the science becomes useful.

Sexuality in dementia sits at the intersection of several systems. There is reward-seeking, attachment, habit, body memory, emotional need, social filtering, and judgement. Dementia can damage those systems unevenly. A person may still desire touch, erotic intimacy, closeness, or the familiar rhythm of partnered sex, while losing the ability to read context, respect privacy, or communicate consent in the way others expect. Reviews of sexuality and intimacy in dementia repeatedly describe this mismatch: the person is not necessarily “sexless,” but they may be less able to express sexuality in socially organised and cognitively coherent ways.

This is one reason the conversation becomes so difficult for partners.

Because the caregiver’s reality is also real.

A spouse may still love the person deeply and yet feel emotionally exhausted, physically depleted, resentful, frightened, lonely, or no longer sexually available in the relationship. A person with dementia may still seek intimacy while the partner is functioning more as nurse, organiser, advocate, and protector than lover. In other cases, desire remains but sexual function changes. Erectile dysfunction, vaginal dryness, pain, medication effects, frailty, reduced stamina, and illness do not erase libido. They often leave desire intact while making sexual expression harder, more frustrating, or more emotionally loaded. The literature on intimacy in dementia consistently frames sexuality as broader than intercourse alone, but it does not support the assumption that sexual desire simply disappears once cognitive decline begins.

That is why this topic cannot be handled honestly unless we also say this plainly:

A spouse or partner, who may also be acting in a caregiving role, is not morally obliged to engage in sexual intimacy simply because the other person still desires it.

This distinction matters. A personal relationship is not the same as a professional care role. Care staff, whether domiciliary carers, agency staff, or care home professionals, must never be placed in a position where sexual intimacy is expected or implied as part of their role.

Sexual expression in dementia must always be understood within the context of the relationship:

- Spouse / partner → a pre-existing intimate relationship, now affected by dementia
- Fellow resident → requires careful consideration of mutual willingness, capacity, and safeguarding
- Care staff → no sexual role whatsoever under any circumstance

Blurring these boundaries is where harm, misunderstanding, and serious ethical breaches occur.

That may sound obvious, but it is exactly the unspoken pressure many partners feel. They are already carrying the emotional labour of loss, the physical labour of care, and the administrative

labour of survival. If sexual expectations remain in the relationship while reciprocity, timing, communication, and mutuality have changed, guilt enters the room very quickly. Good dementia care does not force intimacy, and humane dementia care does not erase it either. It makes room for a truthful middle ground.

That middle ground begins by separating four things that are too often bundled together.

First, sexual desire. A diagnosis does not prove its absence. Second, sexual behaviour. Behaviour may become more overt, more repetitive, or less inhibited because brain control has changed. Third, intimacy. A person may want touch, affection, lying close, kissing, hand-holding, or body contact that is deeply meaningful but not necessarily intercourse. Fourth, consent. Consent is not the same as desire, and desire is not the same as capacity. These distinctions are central in law as well as ethics. Under the Mental Capacity Act framework, capacity is decision-specific and must not be judged simply by diagnosis, age, or behaviour. Families do not automatically gain the power to consent on behalf of an adult merely because dementia is present. If there is doubt, the question is whether the person can understand, retain, weigh, and communicate the specific decision at the relevant time.

This is precisely why care settings often default to restriction.

Restriction is administratively safer.

It is easier to separate residents than to assess what is happening. It is easier to call closeness a safeguarding concern than to work through the uncomfortable layers of autonomy, attachment, privacy, and consent. It is easier to enter rooms without warning, keep doors unlockable, and flatten adult relationships into care tasks. But the same regulatory and dignity frameworks that ask services to manage risk also require them to place the person's wishes, privacy, autonomy, and personal identity at the centre of decision-making. NICE safeguarding guidance emphasises that indicators should not be treated as proof on their own and that actions should be guided by the resident's wishes and feelings. NICE quality standards also state that older people in care homes should be supported to maintain and develop their sense of who they are as individuals. SCIE guidance is equally clear that risk management should minimise restrictions on freedom, choice, and control, and that privacy intrusions require justification.

So what should families and providers do when sexual desire or sexual expression shows up?

Not panic. Not romanticise it. Not suppress it by default.

They need to ask better questions.

Is this mutual, or one-sided? Is this desired, or merely tolerated? Is this affection, habit, comfort-seeking, erotic intent, confusion, or disinhibition? Does one person become distressed, fearful, or withdrawn afterward? Is there evidence of coercion, exploitation, misidentification, or inability to understand what is happening? Are staff intervening because there is true risk, or because sexuality in old age makes them uncomfortable?

Research and guidance around intimacy in care settings recognise that relationships between consenting spouses, long-term partners, or between residents (where appropriate and carefully assessed) can provide comfort, emotional stability, and a sense of connection. However, staff must approach this with clear professional boundaries. Their role is to observe, assess, and safeguard — not to provide, participate in, or enable or support sexual activity directly. The

responsibility of care staff is to ensure that any interaction between individuals is safe, mutually understood, and free from coercion, misunderstanding, or distress.

Where relationships form between residents, the question is not whether intimacy should be automatically allowed or stopped, but whether:

- Both individuals are willing participants
- Both have the capacity to understand the interaction at that moment
- Neither is being influenced, coerced, or misidentifying the other person

This is where structured assessment and careful observation must replace assumption.

And this is where the field still struggles.

The law is stronger on prohibiting non-consensual sexual activity than it is on helping services navigate sexuality where cognition is impaired but humanity remains intact. Recent legal commentary in England and Wales argues that the requirement for contemporaneous consent often leaves advanced dementia particularly difficult to navigate in practice, especially when prior relationships, emotional bonds, and present capacity do not line up neatly. That does not mean the law is wrong to protect people. It means the ethical strain is real, and pretending otherwise helps no one.

The deepest mistake in this area is not simply getting consent wrong. It is getting personhood wrong.

If dementia care only asks, “How do we prevent sexual risk?” it will miss the larger question: “How do we avoid dehumanising someone while protecting them?” That is the line families and providers walk every day. Some people with dementia still want sex. Some want tenderness but not sex. Some show sexualised behaviour that is more about disinhibition than desire. Some lose interest entirely. Some retain erotic identity long after memory declines. The point is not to force one explanation onto all of them. The point is to stop assuming that dementia has already answered the question for us.

Dementia does not automatically remove sexual desire.

What it often removes is privacy, confidence, language, timing, inhibition, and the social protection around desire.

That is why this subject needs more honesty than euphemism.

Not every act of closeness is sex. Not every sexual behaviour is abuse. Not every expression of desire can be acted upon. Not every partner can or should meet it. But if dementia care cannot even admit that sexual desire may still exist, then it has already failed to see the full adult person standing in front of it.

At LAUNEX LTD, we believe this is exactly where dementia care must mature: not by collapsing sexuality into risk, and not by denying safeguarding, but by learning how to interpret human need without stripping away dignity.

## References

- de Medeiros, K., et al. (2016). Sexuality and Intimacy in Dementia. *Journal of Gerontological Nursing*.
- Alzheimer's Society. *Sex and intimate relationships in dementia*
- NICE Guidelines (NG189) – Safeguarding and dignity in care
- SCIE – Mental Capacity Act & Dignity in Care Guidance
- Series, L. (2024). Sexual consent and dementia in England and Wales

© LAUNEX LTD 2026. All rights reserved.

This article is the intellectual property of LAUNEX LTD. No part may be reproduced without permission.

The Launex Dementia Brain Map™ and associated frameworks are proprietary.