Interventions for hypersexuality

Hypersexuality involves persistent and inappropriate sexual behaviour, such as sex talk with foul language not in keeping with previous personality, sexual acts including touching, grabbing, exposing, public masturbating or requesting unnecessary genital care.

Differentiating between normal sexual behaviour and hypersexual behaviour is one of the greatest challenges in developing interventions for hypersexual behaviour among residents in long-term care. People with cognitive impairment may demonstrate appropriate sexual behaviour but in the wrong place. They may confuse private and public areas or mis-identify a stranger as their spouse. Behaviour may also be interpreted as sexual when it has a non-sexual meaning to the individual; public undressing or touching genital areas may be because a person feels hot or is in pain or discomfort.

Hypersexuality may be complicated by misconceptions that older people are no longer interested in sexually intimate behaviour. Staff can be helped to explore their attitudes about sexuality in older people through the use of films and discussion.

Unmet sexual need may be a cause of hypersexual behaviour so residents should be encouraged to participate in safe behaviours that fulfil those needs. Depression and delirium occur commonly with hypersexual behaviour so should be screened for and treated as appropriate. Where no further health improvements can be made, strategies such as clothing that fastens at the back can be helpful and drugs such as antidepressants can be used as they have anti-libido effects. Ethical issues must be carefully considered; any intervention may result in a conflict between the individual’s right to sexual expression and the need to protect other people from physical or mental harm.


Psychological effects of a fall

Post-traumatic stress disorder (PTSD) occurs in a substantial minority of older people post-fall. It is a psychological response that evokes intense fear, helplessness or horror and is characterised by avoidant behaviour, hyperarousal and unwanted re-experiencing of the trauma.

This study found no association between those with PTSD and the severity of the fall injury. The number of falls or previous fall history did not seem to make a difference. Nurses should not assume a relationship between ‘commonsense’ indicators of the extremity of the fall experience and the development of PTSD. However, they should be aware that some older people will require psychological support if they are to resume their normal lives after a fall.


Exercise and sensitivity to insulin

In type 2 diabetes, insulin is produced but there may be some resistance to it. Resistance is increased by obesity and lack of physical exercise, therefore lifestyle changes are important. The body is more sensitive to insulin for 24-72 hours after exercise. Strenuous exercise can lead to hypoglycaemia in patients taking sulphonylureas or insulin so, for optimal glucose lowering, exercise should be performed regularly throughout the week – ideally 30 minutes five times a week. The aim of treatment is to prevent complications. These can be divided into two groups.

Microvascular complications (small vessel):
- Retinopathy – damage to blood vessels in the retina leading to blindness.
- Neuropathy – nerve damage which can be peripheral leading to pain or numbness in feet and legs or autonomic, affecting the bladder and gastric emptying.
- Nephropathy – damage to kidneys leading to renal failure.

Macrovascular complications (large vessel):
- Stroke
- Myocardial infarction.
- Peripheral vascular disease which can lead to lower limb amputation.