**Consent’s Dominion: Dementia and Prior Consent to Sexual Relations[[1]](#footnote-1)**

**Abstract**

In this paper, I answer the following question: suppose that two individuals, C and D, have been in a long-term committed relationship, and D now has dementia, while C is competent; if D agrees to have sex with C, is it permissible for C to have sex with D? Ultimately, I defend the view that, under certain conditions, D can give valid consent to sex with C, rendering sex between them permissible. Specifically, I argue there is compelling reason to endorse the following thesis:

*Prior Consent Thesis*: D, when competent, can give valid prior consent to sex with her competent partner (C) that will take place after she has dementia, assuming that D is the same person as she was when she gave prior consent, meaning that, if D, when competent, gave prior consent to sex with C, then C may permissibly have sex with D.

In section I, I explain both the background and the existing literature on this issue. In section II, I outline relevant stipulations about the kinds of cases I will be examining. In section III, I defend the Prior Consent Thesis. And, in section IV, I address objections to the Prior Consent Thesis.

**Key Words**

Dementia; Consent; Prior Consent; Advance Directives; Sexual Advance Directives.

**Consent’s Dominion: Dementia and Prior Consent to Sexual Relations**

Henry Rayhons and Donna Young married in their 70s. By all appearances, they had a loving and healthy marriage.[[2]](#footnote-2) However, Young was later diagnosed with Alzheimer’s disease and was eventually relocated to a nursing home. While Young lived in the nursing home, Rayhons visited her frequently; Young’s daughters (from her previous husband) believed that, during these visits, Rayhons engaged in sexual intercourse with their mother. Worried that their mother’s condition rendered her unable to consent to sex, Young’s daughters had a BIMS (Brief Interview for Mental Status) test conducted on their mother. The test ruled that Young could not consent to sexual activity. Despite this, Rayhons was accused of having sex with Young eight days after he was informed about her supposed inability to consent; although Rayhons denies that any such sexual activity occurred, he was eventually indicted, tried, and ultimately found innocent of third degree felony sexual abuse.

Although this case may seem extreme, situations in which elderly individuals with dementia want to engage sexual activity are quite common. In these cases, there is a great deal at stake, morally speaking. If people with dementia cannot consent to sexual activity, then Rayhons, despite his history of a loving relationship with Young, raped her. [[3]](#footnote-3) Yet, if Young was capable of giving her consent (and if she did so), then their sexual intercourse was a continuation of the loving relationship they fostered prior to Young’s diagnosis.

In this paper, I answer the following question: suppose that two individuals, C and D, have been in a long-term committed relationship, and D now has dementia, while C is competent; if D agrees to have sex with C, is it permissible for C to have sex with D? Ultimately, I defend the view that, under certain conditions, D can give valid consent to sex with C, rendering sex between them permissible. Specifically, I argue there is compelling reason to endorse the following thesis:

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In section I, I explain both the background and the existing literature on this issue. In section II, I outline relevant stipulations about the kinds of cases I will be examining. In section III, I defend the Prior Consent Thesis. And, in section IV, I address objections to the Prior Consent Thesis.

Before continuing, it is important to acknowledge that the goal of this paper is not to defend an account of what prior consent looks like in institutional or legal contexts; instead, my goal is to establish that prior consent can, in principle, ground consent to future sex. I do not want to ignore these important practical questions, but I believe that the theoretical questions must be answered before proceeding. In that regard, I see this article as following the important division of labor between research that focuses on abstract and theoretical issues in bioethics and research that directly addresses the practical realities of institutional and legal policies. Both areas of research are necessary. My goal is to answer the theoretical question in order to ground future empirical research.[[4]](#footnote-4)

**I: The Relevance and the Literature So Far:**

Dementia is an umbrella term that includes 11 different forms, of which Alzheimer’s is the most common. Although there are differences between forms of dementia, all are characterized by varying degrees of “loss of memory and other mental abilities severe enough to interfere with daily life,” and all are “caused by physical changes in the brain.”[[5]](#footnote-5) For my purposes, it doesn’t matter what kind of dementia D has.

Cases like Rayhons and Young’s are common. In 2017, there were 50 million people with dementia.[[6]](#footnote-6) The elderly, including those with dementia, often have sexual desires and see sex as an integral part of life. In a study of over 3,000 elderly individuals, Lindau found that over 60% of men and women aged 57-64 and roughly 54% of men and women aged 75-85 had sex two to three times per month.[[7]](#footnote-7) Not only do the elderly desire sex, sex benefits their health. Sex helps the elderly avoid depression and loneliness, lowers their risk for cancer or cardiovascular disease, and more.[[8]](#footnote-8)

Overall, there are millions of people with dementia, they have sexual desires, and fulfilling these desires benefits them.[[9]](#footnote-9) However, nursing homes (where many of these individuals reside) typically prohibit people with dementia from having sex with their partners. As White says, “despite the fact that most elderly individuals want to engage in sexual activity, most nursing homes…are reluctant to allow such behavior because of the individuals’ diminished capacity to give consent.”[[10]](#footnote-10) In one extreme case, a woman was “reprimanded by a member of the nursing home staff for snuggling, fully clothed, in bed with her husband during a visit.”[[11]](#footnote-11)

Despite the prevalence of this issue, it is little discussed in philosophy. Philosophers have discussed the nature of consent, its connections with dementia, and the connections between dementia and prior consent (in reference to advance directives). There is a small literature in law reviews about the legal status of individuals with dementia consenting to sex, and there is a large literature in psychology and medicine about how to assess the competency of demented individuals. However, there is only *one* philosophy article that addresses the issue of individuals with dementia consenting to sex.[[12]](#footnote-12) Tenenbaum puts this well: “there are many articles written about end-of-life decision making for elderly adults with dementia, but few about their sexual relationships.”[[13]](#footnote-13) I endeavor to fill this gap in the literature.

**II: Stipulations:**

Although the case of Rayhons and Young is the starting point for this paper, several crucial details are unknown in that case. For that reason, I instead discuss a hypothetical case involving two partners, C and D. C will refer to the competent partner, while D will refer to the partner with dementia.[[14]](#footnote-14) The reader is free to alter the genders of the individuals in any way. I will refer to D as a female and C as a male. The case of C and D will involve numerous stipulations.

*First*, an individual’s consent is valid if and only if it is informed, rational/competent, and voluntary. Conversely, one’s consent is invalid if and only if it is deceived, irrational/incompetent, or coerced. I will take it as a working assumption that if an individual’s consent is invalid, it is invalidated in virtue of being coerced, incompetent/irrational, or deceived. *Second*, C and D are individuals who have been in a long-term, committed relationship with no history of abuse. *Third*, prior to D’s diagnosis, C and D’s relationship often involved consensual sex and that they are familiar with each other’s verbal and non-verbal sexual cues. *Fourth*, C is fully competent. *Fifth*, D has dementia, and her condition has cognitively impaired her. Dementia spans a wide range of degrees of cognitive impairment. Individuals with very mild dementia are clearly competent to consent to a wide variety of things. And, individuals with *extreme* dementia (i.e. non-verbal and non-communicative) can clearly not consent to anything. I am not interested in the question about individuals whose dementia is so bad that they have lost all awareness and ability to communicate. It seems clear to me that these individuals cannot consent to sex. Instead, I am interested in whether individuals with mild to severe dementia can consent to sex. So, by stipulation, D’s dementia does not rise to the extreme level outlined above; rather, D’s dementia falls somewhere on the spectrum from very mild to severe. So, although she is cognitively impaired, D can still communicate, still has a sense of self, etc. *Sixth*, in the situations under discussion, D has at least given *assent* to sex with C. Consent and assent are both a kind of agreement, a ‘yes.’ But, assent is a ‘yes’ that is weaker than consent and which is not thought, on its own, to render an action permissible when it otherwise would not have been. This stipulation is crucial, as it excludes cases where D does not even assent to sex with C. In the cases that I will examine, D has either asked for sex from C or has agreed to sex with C after being asked. I will not be evaluating any case in which D gives concurrent *dissent* to sex with C. I take it to be clear that sex is impermissible in those cases. *Seventh*, no other consent invalidating conditions (coercion, deception, etc.) obtain between C and D. *Eighth*, I am only addressing cases of sex between C and D. Much of the literature on this topic has addressed cases in which two people who both have dementia want to have sex with each other, or about cases in which an individual with dementia wants to begin a new sexual relationship with someone who has not been her long-term partner. I will not discuss those cases. *Ninth*, I don’t assume a view about the nature of consent.[[15]](#footnote-15) *Tenth*, when I discuss consent, I assume that the action in question isn’t independently wrong. In the cases I examine, the presence or absence of consent makes an action permissible or impermissible respectively, all things considered.[[16]](#footnote-16)

**III. The Prior Consent Thesis:**

In this section, I defend the Prior Consent Thesis, which is the following:

*Prior Consent Thesis*: D, when competent, can give valid prior consent to sex with her competent partner (C) that will take place after she has dementia, assuming that D is the same person as she was when she gave prior consent, meaning that, if D, when competent, gave prior consent to sex with C, then C may permissibly have sex with D.

Even if D cannot give valid consent to sex in the moment, if when D was competent, she gave valid prior consent to sex with C, then their current sex is permissible. Again, D gives assent in the moment to sex.[[17]](#footnote-17) My argument here is that, if the conditions of the Prior Consent Thesis obtain, then C may act on D’s concurrent assent to sex, even if it isn’t valid concurrent consent. For the sake of argument, the reader can stipulate that D cannot give valid concurrent consent to sex. Given this, my argument here will establish that, even if D cannot give valid concurrent consent, her prior consent and concurrent assent can make sex between her and C permissible.

I first argue that D can, when competent, give valid prior consent to sex that will take place after she has dementia. I then argue that this prior consent is valid only if D is the same person as she was when she gave prior consent. With these claims defended, the Prior Consent Thesis will be established.

*i. Why D Can Give Valid Prior Consent to Sex:*

My argument that D, when competent, can give valid prior consent to sex that will take place after she has dementia is the following:

**P1**: D, when competent, can give prior consent to actions that will affect her bodily autonomy after she has become permanently impaired.

**P2:** sexual autonomy is a species of bodily autonomy.

**P3:** if sexual autonomy is a species of bodily autonomy, then if D, when competent, can give prior consent to actions that will affect her bodily autonomy after she has become permanently impaired, then D can, when competent, give prior consent to actions that will affect her sexual autonomy after she becomes permanently impaired.

**C1:** thus, if D, when competent, can give prior consent to actions that will affect her bodily autonomy after she has become permanently impaired, then D can, when competent, give prior consent to actions that will affect her sexual autonomy after she becomes permanently impaired (P3, P2).

**C2:** thus, D can, when competent, give prior consent to actions that will affect her sexual autonomy after she becomes permanently impaired (C1, P1).

With the argument outlined, I defend each premise.

**P1**: D, when competent, can give prior consent to actions that will affect her bodily autonomy after she has become permanently impaired.

We can give prior consent to many things. If A is trying to quit smoking, he can ask B to stop him from buying cigarettes in the future. If A knows that his phone will distract him as he writes his paper, he can give it to B and tell him to not give it back until he finishes writing, even if he asks for it. Furthermore, A can give prior consent to things that affect his autonomy and which happen after he has entered a permanent state of cognitive impairment. For example, A can, while competent, sign a medical advance directive that dictates how he should be treated if he enters a permanent vegetative state or becomes demented. So, not only is prior consent valid, it extends to actions that affect an individual’s autonomy after he becomes permanently incompetent. To deny this is to deny the possibility of any medical advance directives, which I take to be implausible.[[18]](#footnote-18) Essentially, P1 should be plausible to anyone who believes that following medical advance directives is permissible, which is the dominant view.

**P2:** sexual autonomy is a species of bodily autonomy.

P2 makes the obvious claim that sexual autonomy is a kind of bodily autonomy. Individuals exercise autonomy and control over their bodies, and sexual interactions are done with bodies. As such, sexual autonomy is a subset of bodily autonomy.

**P3:** if sexual autonomy is a species of bodily autonomy, then if D, when competent, can give prior consent to actions that will affect her bodily autonomy after she has become permanently impaired, then D can, when competent, give prior consent to actions that will affect her sexual autonomy after she becomes permanently impaired.

If, as P1 holds, D can give valid prior consent to things that affect her bodily autonomy after she becomes permanently incapacitated, and if, as P2 holds, sexual autonomy is a species of bodily autonomy, it follows that D can give valid prior consent to things that will affect her sexual autonomy after she becomes permanently incapacitated. Essentially, if medical advance directives are permissible, then so are sexual advance directives.[[19]](#footnote-19) With the premises established, the conclusions follow:

**C1:** thus, if D, when competent, can give prior consent to actions that will affect her bodily autonomy after she has become permanently impaired, then D can, when competent, give prior consent to actions that will affect her sexual autonomy after she becomes permanently impaired (P3, P2).

**C2:** thus, D can, when competent, give prior consent to actions that will affect her sexual autonomy after she becomes permanently impaired (C1, P1).

*ii. Why D Must Be the Same Person:*

I have argued that D can, when competent, give prior consent to sex that will take place after she becomes permanently incompetent. However, it must be the case that D, in the present, is the same person that gave prior consent to sex with C. In the debate about advance directives, the question of personal identity is crucial in determining if an individual’s prior consent to an advance directive should bind her current conduct. Some argue that prior consent to an advance directive shouldn’t bind currently demented individuals, because they aren’t the same person as the person who signed the directive.[[20]](#footnote-20) I find this position especially plausible when it comes to sexual consent. I take the following to be a plausible principle:

*Same Person*: a person, D, cannot give prior consent to sex on behalf of different a person, D\*, even if D\* occupies the same body that D used to occupy.

If D used to occupy a body (B) but no longer occupies B, and if someone else (D\*) occupies B, then D cannot consent to sex on behalf of D\*, even though D\* occupies the body that D used to occupy. Consider a case in which two competent partners, X and Y, agree to have sex tonight. Somehow Y’s consciousness is switched with Z’s consciousness. Z (who is competent) now occupies Y’s body, and Y occupies Z’s body. Y, when he was in his original body, gave prior consent to have sex tonight with X. But, Z now occupies Y’s body and doesn’t want to have sex with X. It is absurd to say that X can still have sex with Y’s body. This case is meant to illustrate the intuition that occupying a particular body doesn’t obligate one to act in accordance with the promises or past consent of the person who previously occupied that body. I see no reason why this would change if we altered the case so that Y ceases to exist when the consciousness switch occurs and so that Z has diminished competence. It would still be true that Y’s past consent cannot serve as consent on behalf of Z. To return to C and D, this means that D’s prior consent to sex with C is valid only if D is the same person who gave prior consent to C.

Now, the Prior Consent Thesis has been established. But, for their sex to be permissible, C must justifiably believe that D satisfies the conditions of the Prior Consent Thesis. Otherwise, it is impermissible for him to have sex with her. Given their history, C could easily know if D has given prior consent. And, by testing her memory, C can establish if D is the same consciousness as she used to be.[[21]](#footnote-21) C can ask D demographic questions about what she knows about herself, her family, etc. He can ask her if she knows who he is. He can ask her if she understands what sex is, listen as she expresses her wishes, and wait a few weeks before engaging in sex to ensure that her sexual preferences are stable. If C determines that D answers these questions with consistency and accuracy, then C can justifiably believe that D is competent to consent to sex. Recall that C and D have been committed, long-term partners in a relationship that involved a history of consensual sex, and both know each other’s verbal and non-verbal sexual cues. Because of this, C has considerably more epistemic access to D’s state of mind than the average person. He can read her cues, knows her past preferences, etc. This means that C is best suited to know if D is answering these questions correctly. And, C is clearly best suited to read D’s non-verbal cues as indicators of her comfort, etc.[[22]](#footnote-22)

It is unclear what, precisely, constitutes prior consent to sex. A legal sexual advance directive signed prior to becoming incompetent would certainly be sufficient to ground prior consent. But, there may be less formal ways to ground prior consent. The purpose of this paper isn’t to defend an account of what prior consent looks like but rather to establish that it can, in principle, ground consent to future sex. Consequently, I end the account here.[[23]](#footnote-23)

**VI. Objections to the Prior Consent Thesis:**

*i. Advance Directives:*

The objector might argue that my view commits me to the controversial position that currently incompetent individuals can alter advance directives they signed when they were competent. In short, I’m arguing that D’s prior consent to sex with C can be trumped by her concurrent dissent from sex with C. It seems like the same would have to be said of, for example, a Do Not Resuscitate order that D signed when competent. If I am claiming that D’s concurrent dissent defeats her prior consent in the case of a sexual advance directive, then it seems as if I’m committed to this in the case of any other kind of advance directive. Although some have defended this view, for reasons beyond the scope of this paper, I take this to be an implausible conclusion. And, given that it is the dominant view to hold that irrevocable advance directives are permissible, I will assume that denying this view is a considerable cost for my view.

Much of the debate about advance directives concerns cases in which, at t1, a competent person signs an advance directive but then, after she becomes incompetent, desires, at t2, to alter the directive. This is a complicated debate, but my view avoids it altogether. In the cases I consider, there is no conflict between D’s past desire for sex and her current desire for sex. Again, D has given concurrent assent to sex. So, if she gave valid prior consent, and if she gives concurrent assent, there is no conflict of desires between D at t1 and D at t2. Thus, my view avoids the issue altogether.

But, the objector might press the point further: what if D does dissent in the moment from having sex with C?[[24]](#footnote-24) In such a case, I want to maintain that D’s past consent is defeated by her concurrent dissent. This seems like the intuitively correct result; nobody should have sex that they actively dissent from in the moment. But, again, I do not want to be committed to this revocability in the case of general medical advance directives. The objector could say that my response above is unsatisfactory, because I’m simply assuming away the problematic case. Thus, argues the objector, my view is committed to saying that if the concurrent dissent of an incompetent individual trumps her prior consent in the case of sexual advance directives, then the same must be true of medical advance directives.

There is a plausible way to deny this and to maintain that sexual advance directives are revocable by an incompetent person while also saying that medical advance directives are not revocable by an incompetent person. This is the case for several reasons. First, it seems reasonable to say that the power of concurrent dissent is built into a sexual advance directive in a way that it is not built into a medical advance directive. When D agrees to a sexual advance directive, she is saying to C, “I agree to have sex with you in the future*, only if I want to at the time*;” she is not saying, “I agree to have sex with you in the future, *no matter what my desires are in the moment*.” But, in the case of a medical advance directive, D is saying, “I will that my daughter has legal power of attorney over my accounts when I’m incompetent, *no matter what I want at the moment*;” she is not saying, “I will that my daughter has legal power of attorney over my accounts, *only if I want her to*.” If this is a correct account of the content of each kind of advance directive, then sexual advance directives can be revoked by concurrent dissent, because they have this feature built into them. But, medical advance directives cannot be revoked by concurrent dissent, because they have the opposite built into them. This is a coherent, and I believe plausible, way that my view can maintain the revocability of sexual advance directives and the irrevocability of medical advance directives.

Another reason that I can maintain this difference is by appealing to the relative complexities of the choices involved in medical and sexual advance directives. In general, there is both (1) more at stake and (2) more complexity involved in the decision surrounding medical advance directives than sexual advance directives. Medical advance directives are, in many cases, a literal matter of life and death. Although sexual advance directives are certainly important, they do not rise to this level. The standard required for competence is relative to each decision. Since the decision to alter a medical advance directive is more important and more complex, the standard of competence required is higher. Thus, D can be competent to alter a sexual advance directive without being competent to alter a medical advance directive.

The objector might then respond by asking about a potential case in which an individual were to sign a sexual advance directive that took the form, “I agree that my partner may have sex with me when I’m incompetent, *even if I don’t want to in the moment*.” The objector might then argue that, if in this case I hold that we should not allow such an agreement to be enforced, this would raise the original problem about medical advance directives again.

I have several responses. First, it is highly unlikely that anyone would agree to such a directive. So, the objection is irrelevant even if it’s true. Second, if someone were to sign such a directive, there are still reasons to think that this kind of sexual advance directive can be revoked by concurrent dissent without having to say that a medical advance directive can be revoked by concurrent dissent. This is the case, because, between the two kinds of directives, there is a difference in both complexity and harms. The complexity point has already been described above and still applies here. But, it is important to note the difference in the harms between the two kinds of directives. If we allow D’s concurrent dissent to revoke the extreme, unconditional sexual advance directive mentioned above, only her sexual interests are set back. But, if D’s concurrent dissent could revoke her medical advance directives, this would involve a setback of her interests in how she dies and how her body is cared for. Although sexual interests are important, they are not as important as interests about one’s end of life care. This provides a reason to think that sexual advance directives can be revocable while medical advance directives are not.

I conclude that my account is not committed to saying that the revocability of D’s sexual advance directive entails that her medical advance directives are revocable.

*ii. Liberto’s Argument Against Sexual Promises:*

Liberto has recently argued that sexual promises are morally problematic. One might think that a sexual advance directive is a form of sexual promise and that my account runs afoul of Liberto’s argument. In this section, I explain Liberto’s account and argue that it does not apply to my view.

 Liberto begins with a distinction between “promises to perform sexual acts” (positive sexual promises) and “promises to refrain from sexual acts” (negative sexual promises).[[25]](#footnote-25) Liberto argues that both kinds of promises do, in fact, generate a promissory obligation. But, she further argues that although the promisor of both positive and negative sexual promises does create an obligation in so promising, the promisee is either under an obligation “to refuse the promise,” of, if he has already accepted it, he is obligated “to release the promisor.”[[26]](#footnote-26)

 The objector might argue that a sexual advance directive constitutes a positive sexual promise, which Liberto’s argument has rendered problematic. If so, then I would have to contend with Liberto’s compelling argument. However, there is a simple solution: sexual advance directives are not promises at all. In making a sexual advance directive with C, D is not making a promise to have sex with C in the future; rather, D is saying that C may permissibly have sex with her in the future if she tokens consent. When she forms a sexual advance directive, D does not agree to owe sex to C or to enter any obligation that would require her to have sex with C. She merely states her wishes that such an encounter be allowed, although not required, if her future self desires it. But, if a sexual advance directive were a promise, D would be obligated to have sex with C, and C would be entitled to have sex with D.[[27]](#footnote-27) This is not the kind of claim involved in a sexual advance directive. As such, I conclude that sexual advance directives are not promises and thus that they do not fall prey to Liberto’s argument against sexual promises.

*iii. Personal Identity and Applicability:*

Lastly, one might object that, because of my restriction based on personal identity, my view is practically irrelevant. As the objector argues, the number of individuals who have dementia and who satisfy the *Same Person* principle is so low that most sexual advance directives would be unenforceable, because they would no longer satisfy the conditions about personal identity.

This is not the case. The empirical evidence shows that individuals with dementia have stable and accurate memories and preferences even into the late stages of their illness. Much of this empirical evidence is based on surveys administered to people with dementia at two different times, one week apart. These surveys ask these individuals demographic questions about their lives and general questions about their preferences. Across the board, individuals with dementia have both consistent and accurate answers to these questions at high rates across time.[[28]](#footnote-28) If this is true, then individuals with dementia maintain personal identity even into the late stages of their condition.[[29]](#footnote-29) Thus, my view is very applicable, as it’s false to claim that most people with dementia are distinct persons from the person who occupied their pre-dementia body. This is certainly news, because philosophers have frequently assumed, a priori, that the demented fail to meet the cognitive conditions of consent. Indeed, McMahan simply asserts that “the preferences of the demented are notoriously arbitrary, whimsical, and ephemeral.”[[30]](#footnote-30) This claim doesn’t fit the evidence.

**Conclusion:**

I have argued that, if valid prior consent was given, partners who have been in a committed, long-term relationship may continue having sex after one partner becomes demented. If I am correct, then policies in the status quo unjustly prevent demented individuals from engaging in sexual expression.

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2. References to the descriptive features of the Rayhons-Young case are from Belluck, P. (2015, April 27). An Intimacy That Outlasted Dementia. *The New York Times*, retrieved from https://www.nytimes.com/2015/04/28/health/an-intimacy-that-outlasted-dementia.html, and from Belluck, P. (2015, April 13). Sex, Dementia and a Husband on Trial at Age 78. *The New York Times,* retrieved from https://www.nytimes.com/2015/04/14/health/sex-dementia-and-a-husband-henry-rayhons-on-trial-at-age-78.html. As Belluck says, “it is widely agreed that the Rayhonses had a loving, affectionate relationship” (Ibid). [↑](#footnote-ref-2)
3. My argument does not rely on the view that rape should be understood as non-consensual sex. [↑](#footnote-ref-3)
4. For reference, Boni-Saenz has proposed a legal account of sexual advance directives. See Boni-Saenz, A. (2016). Sexual Advance Directives. *Alabama Law Review* *68* (1), 1-47. [↑](#footnote-ref-4)
5. Alzheimer’s Association (Accessed 2018). *Tests for Alzheimer’s Disease and Dementia*. Retrieved from https://www.alz.org/alzheimers\_disease\_steps\_to\_diagnosis.asp. For a summary of the different types of dementia see Foxx, J. (2016). Dementia Sex Culture: Out With the Old, in With the New. *Journal of the American Academy of Matrimonial Lawyers* *29*, 187-217, pp. 192-193. [↑](#footnote-ref-5)
6. Alzheimer’s Disease International (Accessed 2018). *Dementia Statistics.* Retrieved from https://www.alz.co.uk/research/statistics. [↑](#footnote-ref-6)
7. Lindau, S.T., Schumm, L.P., Laumann, E.O., Levinson, W., O’muircheartaigh, C.A., Waite, L.J. (2007). A Study of Sexuality and Health Among Older Adults in the United States. *The New England Journal of Medicine* *357*, 762-774, p. 766. [↑](#footnote-ref-7)
8. Tenenbaum, E. M. (2009). To Be or To Exist: Standards for Deciding Whether Dementia Patients In Nursing Homes Should Engage In Intimacy, Sex, And Adultery. *Indiana Law Review* *42*, 674-720, pp. 680-681. [↑](#footnote-ref-8)
9. It is important to note (as an anonymous reviewer pointed out to me) that the nature of sexual intimacy for the elderly may change dramatically. Some elderly individuals no longer desire intercourse but instead desire less intrusive forms of sexual intimacy. Policies in the status quo prevent even this kind of intimacy for demented individuals. [↑](#footnote-ref-9)
10. White, M.C. (2010). The Eternal Flame: Capacity to Consent to Sexual Behavior Among Nursing Home Residents With Dementia. *The Elder Law Journal* *18*, 133-158, p. 133. [↑](#footnote-ref-10)
11. Ibid: 139. [↑](#footnote-ref-11)
12. See Tarzia, L., Fetherstonhaugh, D., Bauer, M. Dementia, Sexuality and Consent In Residential Aged Care Facilities. *Journal of Medical Ethics* *38*, 609-613. [↑](#footnote-ref-12)
13. Tenenbaum, op. cit. note 7, p. 675. [↑](#footnote-ref-13)
14. Dementia is an umbrella term that encompasses many different conditions, of which Alzheimer’s is by far the most common. I will be discussing dementia broadly and will not be addressing the details of specific kinds of dementia. For a helpful summary of the different types and rates of dementia see Foxx, op. cit. note 4, pp. 192-193. [↑](#footnote-ref-14)
15. There are three main views about the nature of consent: (1) mentalism, which holds “that performing the appropriate kind of mental act is not just necessary but also sufficient to bring about the normative change distinctive of permissive consent,” (2) a performative view, which holds that consent is an external communicative act, and (3) a hybrid view which says that consent involves both mental and communicative features (Manson, 2016, 3318). Mentalism is defended by Hurd, H. (1996). The Moral Magic of Consent. *Legal Theory* *2*, 121-146; Alexander, L. (1996). The Moral Magic of Consent (II). *Legal Theory*. *2*, 165-174; Alexander, L. (2014). The Ontology of Consent. *Analytic Philosophy* 55 (1), 102-113; and Westen, P. (2004). *The Logic of Consent*. Aldershot: Ashgate. The performative view is defended by Wertheimer, A. (2000). What Is Consent? And Is It Important? *Buffalo Criminal Law Review* *3* (2), 557-583; Wertheimer, A. (2003). *Consent to Sexual Relations*. Cambridge: Cambridge University Press; den Hertogh, G. (2011). Can Consent Be Presumed? *Journal of Applied Philosophy* *28* (3), 295-307; and Millum, J & Bromwich, D. Understanding, Communication, and Consent. *Ergo* *5* (2), 45-68. The hybrid theory is defended by Miller, F., & Wertheimer, A. (2009). Preface to a Theory of Consent Transactions: Beyond Valid Consent. In F. Miller & A. Wertheimer, *The Ethics of Consent: Theory and Practice* (pp. 79-106). Oxford: Oxford University Press; Dougherty, T. (2015). Yes *Means* Yes: Consent as Communication. *Philosophy and Public Affairs* *43*, 224-253; Dougherty, T. (2018). On *Wrongs and Crimes*: Does Consent Require Only an Attempt to Communicate? *Criminal Law and Philosophy*. 1-15.; Manson, N. (0216). Permissive Consent: a Robust Reason-Changing Account. *Philosophical Studies.* *173* (12), 3317-3334 rejects all three views and defends a view that, by my lights, seems closest to the hybrid view. [↑](#footnote-ref-15)
16. I am not claiming that consent is always a sufficient condition for the permissibility of an action. One can consent to actions that are, all things considered, wrong. This is in keeping with how consent is discussed in the literature (Dougherty 2015, op. cit. note 13, p. 226). [↑](#footnote-ref-16)
17. Here, I agree with Dougherty that “present dissent trumps…past consent” (Dougherty, T. (2014). Fickle Consent. *Philosophical Studies* *168* (1), 25-40, p. 26). But, as stated previously, I am not discussing cases of present dissent. [↑](#footnote-ref-17)
18. Although it is the minority position, some people deny the permissibility of advance directives. See Dresser, R. (1986). Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law. *Arizona Law Review* *373*, 373-405; Dresser, R. (1993). Confronting the ‘Near Irrelevance’ of Advance Directives. *Journal of Clinical Ethics* *5* (1), 55-56; Dresser, R. (1995). Dworkin on Dementia: Elegant Theory, Questionable Policy. *The Hastings Center Report* *25*(6), 32-38. [↑](#footnote-ref-18)
19. For a recent legal and philosophical discussion of sexual advance directives, see Boni-Saenz, op. cit. note 3. Although Boni-Saenz defends the same conclusion that I do, there are important differences between our arguments. First, he is mainly focused on the legal and institutional features of sexual advance directives. Second, his argument contains no discussion of how personal identity connects with sexual advance directives. Third, he does not defend sexual advance directives, as I do, by linking bodily and sexual autonomy. [↑](#footnote-ref-19)
20. Dresser (1986, op. cit. note 16) was the first to raise this objection. As DeGrazia summarizes this, “in certain cases in which a patient undergoes massive psychological change, the individual who exists after such change is literally a (numerically) distinct individual from the person who completed the directive” (Degrazia, D. (1999). Advance Directives, Dementia, and ‘The Someone Else Problem.’ *Bioethics* *13* (5), 373-391, p. 374). [↑](#footnote-ref-20)
21. Here, I assume a continuity of consciousness view of personal identity. [↑](#footnote-ref-21)
22. One might wonder how my account would handle a case in which D is the same person but does not recognize C. In such a case, their sex may be permissible or not, depending on the content of their previous agreement. If their agreement said, “you may have sex with me if I’m the same person in the future and if I want it at the time, even if I don’t recognize you,” then this sex strikes me as permissible. However, if their agreement said, “you may have sex with me if I’m the same person and if I want it at the time, and only if I recognize you,” then this sex would not be permissible. I’m thankful to an anonymous reviewer for bringing this case to my attention. [↑](#footnote-ref-22)
23. For a logistical discussion of what sexual advance directives might look like, see Boni-Saenz, op. cit. note 17. An anonymous reviewer prompted me to address the fact that dementia can lead to aggressive sexual behavior in the demented patient, thus making the chance of rape or sexual assault more likely. This is an important concern, but there is reason to think that it is unlikely. According to a 2016 review article that surveyed research on dementia and sexuality from 1950 to 2014, Cipriani et al. found that “the most likely change in the sexual behavior of a person with dementia is indifference”(Cipriani, G., Ulivi, M., Danti, S., Lucetti, C., Nuti, A. (2016). Sexual disinhibition and dementia. *Psychogeriatrics* *16*, 145-153, p. 145). Furthermore, there is evidence that aggressive sexual behavior (or hyper-sexuality) is either uncommon or only slightly common among individuals with dementia. As Stratford says, “prevalence rates of such behaviour [hyper-sexuality in demented patients] vary significantly between 2% (Devanand et al., 1992) and 25% (Szasz, 1983)” (Stratford, J. (2017). Sexuality and Dementia. In D. Ames, J.T. O’Brien, & A. Burns, *Dementia* (pp. 285-291). London: CRC Press, p. 287). It is also possible that the competent partner might be more likely to abuse the demented partner. Both concerns are important, but neither undermines my thesis. Furthermore, institutional solutions could be devised to prevent such problems. [↑](#footnote-ref-23)
24. As an anonymous reviewer pointed out to me, there are many reasons why individuals with dementia would dissent from sex (e.g. vaginal dryness, arthritis, and more). If these conditions become so severe that these individuals no longer desire sex, then, according to my argument, their concurrent dissent should trump their prior consent. [↑](#footnote-ref-24)
25. Liberto, H. (2017). The Problem with Sexual Promises. *Ethics* *127* (2), 383-414, p. 383. [↑](#footnote-ref-25)
26. Ibid: 385. [↑](#footnote-ref-26)
27. Here, I follow Liberto in understanding a promissory obligation as “a directed duty to a promisee such that the promisor wrong the promisee by breaking the promise” (Ibid: 387). [↑](#footnote-ref-27)
28. This evidence is mainly found in Feinberg, L.F., & Whitlatch, C.J. (2001). Are Persons With Cognitive Impairment Able to State Consistent Choices? *The Gerontologist* *41* (3), 374-382; Mills, M.A.., and Coleman, P.G. (1994). Nostalgic Memories in Dementia-A Case Study. *The International Journal of Aging and Human Development 38* (3), 203-219; Whitlatch, C.J., Feinberg, L.F., and Tucke, S. (2005). Accuracy and Consistency of Responses from Persons with Cognitive Impairment. *Dementia* *4* (2), 717-183; Wilkins, J.M. (2017). Dementia, Decision Making, and Quality of Life. *AMA Journal of Ethics* *19* (7), 637-639; Clark, P. A., Tucke, S.S., Whitlatch, C.J. (2008). Consistency of Information from Persons with Dementia: An Analysis of Differences by Question Type. *Dementia* *7* (3), 341-358. [↑](#footnote-ref-28)
29. This assumes a continuity of consciousness account of personal identity. [↑](#footnote-ref-29)
30. McMahan, J. (2002). *The Ethics of Killing: Problems at the Margins of Life*. Oxford: Oxford University Press, pp. 497-498. [↑](#footnote-ref-30)