Inappropriate sexual behaviour and dementia: An exploration of staff experiences

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Abstract
Research assessing the impact of inappropriate sexual behaviour (ISB) on staff working in dementia care is circumscribed, yet studies from comparable settings indicate that ISB appears uniquely challenging, particularly to personal and cultural values. This study explored staff experiences of ISB exhibited by older adults with a dementia. Fourteen staff working within an in-patient setting were interviewed. Participants’ experiences of ISB appeared underpinned by complex social and psychological processes. Shock, embarrassment and incomprehension were prominent when ISB was initially encountered. Knowledge of dementia, familiarity with patients and social norms were important in contextualising ISB and staff often minimised its impact by construing a lack of capacity. Feelings about ISB appeared equivocal and findings suggest that the effect of ISB should be routinely considered in preparing staff who work within dementia care.

Keywords
dementia, grounded theory, inappropriate sexual behaviour, staff experience

Introduction
Over 80% of people with a dementia exhibit behaviours that are perceived as challenging (Lonergan, Luxenberg, Colford, & Birks, 2002; Scott et al., 2002), and may include verbal/physical aggression, wandering and self-injury. Managing challenging behaviour is demanding, is associated with staff burnout and sub-optimal care, and can compromise
community living of those who present with the behaviour (Feeney, Ylvisaker, Rosen, & Greene, 2001; Hallberg & Norberg, 1995). Such challenging behaviour will become familiar to more caregivers as worldwide prevalence of dementia grows and it seems important for care providers to understand how individuals, families and staff are affected so that sensitive and effective interventions may be developed and implemented.

Inappropriate sexual behaviour

‘Sexuality is with us from the moment of birth to the moment of death’ (Zilbergeld, 2004, p. 15) and is a fundamental part of being human. When a person’s sexual expression is affected by dementia, confusion, distress and embarrassment may ensue, leading to social isolation for familial caregivers and reluctance to accept social support (Robinson, 2003). Indeed, inappropriate sexual behaviour (ISB) has been identified as a significant corollary of the dementias (National Institute for Clinical Excellence & Social Care Institute for Excellence, 2006), and although less frequent than other challenging behaviours, it is still clinically significant with over 60% of staff working in aged care facilities reporting ISB at least once a week (Cubit, Farrell, Robinson, & Myhill, 2007).

The prevalence of ISB exhibited by people with a dementia varies between 1.8% and 17.5% (Alagiakrishnan, et al., 2005; Johnson, Knight, & Alderman, 2006), although this is likely to be an underestimate as literature is scarce and definitions obscure. An extensive review of ISB (Johnson et al., 2006) revealed a multitude of definitions, including ‘sexual advances’, ‘hypersexuality’, ‘propositioning’ and ‘inappropriate commentary’. Following their review, ISB has been defined as ‘a verbal or physical act of an explicit, or perceived, sexual nature, which is unacceptable within the social context in which it is carried out’ (Johnson et al., 2006, p. 688).

Its precise aetiology has not been defined; rather, various neurobiological, psychological and environmental explanations have been offered (Guay, 2008; Johnson et al., 2006). Frontal cortex and hypothalamic pathology have been implicated, as well as psycho-social factors, such as being attended to by opposite-sex caregivers (Black, Muralee, & Tampi, 2005) and loss of self-esteem and/or control compounded by a need for intimacy (Robinson, 2003; Stewart, Knight, Alderman, & Hayward, 2010).

Impact on staff

Literature investigating the effects of ISB has been restricted to forensic and traumatic brain injury populations, with findings highlighting adverse effects on staff and client wellbeing. Sexual behaviour seems particularly challenging with its capacity to challenge staff attitudes (Hughes & Hebb, 2005). Research also indicates that staff feel uncomfortable with issues around sexuality, burnout is common, training is infrequent (Hughes & Hebb, 2005; Robinson, 2003), and Bezeau, Bogod, and Mateer (2004) found that almost all rehabilitation professionals reported that ISB affected rehabilitation practices. Some have argued that staff regard ISB as less problematic than other behavioural disturbances, such as aggression, and therefore do not report it (Matsuoka, Miyamoto, Ito, & Kurita, 2003). However, both nebulous definitions of ISB and transcultural differences in its construction may render identification and subsequent reporting difficult.

The circumscribed literature regarding staff experiences of ISB exhibited by older people with a dementia, and the poor and variable operationalisation of the phenomenon, suggests
there is insufficient awareness of the potential impact on staff and clients (Johnson et al., 2006; Knight et al., 2008). Better understanding may well enhance quality of care for both those living with dementia and their families and enhance staff development and wellbeing. Consequently, this study aimed to provide a detailed exploration of how in-patient staff experience ISB exhibited by older people with a dementia. This study also aimed to understand how staff feel about managing ISB and whether their experience was similar to or different from experiences of other behaviours (i.e. aggression).

**Method**

Due to the paucity of existing research, a qualitative approach was utilised. Semi-structured interviews were used to elicit data within a grounded theory (GT) methodology (Charmaz, 2006) to seek patterns to illuminate social and psychological processes in this previously unexplored area. Grounded Theory, like most qualitative methods, is not a ‘unitary’ approach (Henwood & Pidgeon, 2003; Banister, Burnam, Parker, Taylor & Tindall, 1994) and can be considered from a range of positions, the corpus of which is based in pragmatism or epistemology (Grbich, 1999). A social constructivist GT was adopted for this study since it aimed to understand the phenomena of ISB by abstracting a theoretical framework in which ‘realities’ are essentially created and interpreted in interaction (Charmaz, 2006; Cutliffe, 2000).

Researchers should expound any preconceptions, experiences and views regarding their area of interest (Henwood & Pidgeon, 2003; Meyrick, 2006). At the time the research was undertaken, the first author had seven years clinical experience within the National Health Service (NHS), two of which were spent in older adult services. All authors had experienced incidents of what they construed as ISB exhibited by people with a dementia, and their intense emotional reactions had challenged notions of sexuality and dementia. Clinically, the authors had interests in Personal Construct Psychology, psychodynamic thinking and staff distress. To monitor influences and for purposes of transparency, a reflective diary was kept, including process notes taken post-interview. This was used to log tentative ideas, early memos and formulations about the data, and to enhance reflexivity.

**Procedure**

The research proposal was ratified by the relevant local Ethics Committee and the Research and Development Departments for the sponsoring NHS Trust and the hospital in which the study took place. The hospital where the research was conducted offered a range of services for older people and adults, including secure services, specialist dementia and challenging behaviour services and palliative care. The majority of patients were male (74%). Given the conduct of research in a closed system, additional measures were taken to protect participant and patient confidentiality; anonymising transcripts, modifying potentially identifiable information and gathering rudimentary demographic information.

**Recruitment**

Two hundred participant information packs were issued to senior clinicians/ward managers for distribution to staff at ward level. Signed, informed consent to be approached and to participate was required prior to interview. Participants were required to have experienced at least one memorable incident of ISB exhibited by an older adult with a dementia.
Participants

Fourteen participants were interviewed: nine females and five males. Thirteen were White British and one was White European, with six staff being qualified and eight unqualified. Participants comprised nine nursing staff and five allied health professionals. Ages ranged between 18 and 65 years. All participants had at least one year’s experience of working with older adults with a dementia; three people had over 15 years’ experience. Participants’ experiences of ISB varied; for some it occurred regularly, for others it was encountered infrequently.

Interviews lasted between 30 and 90 minutes and were conducted between July 2008 and February 2009. All were digitally recorded and transcribed verbatim by the first author, demonstrating commitment to and a prolonged engagement with the data (Yardley, 2000).

Interview schedule

The initial interview schedule was not static; new questions were added as interviews progressed, integrating domains raised by participants (i.e. theoretical sampling) consonant with Charmaz (2006). Additional questions included patient sexuality, ISB experienced by a patient of the same sex, patient gender and the perceived differences between stages of dementia. As codes developed and memos were elaborated, questions designed to test out hypotheses were asked.

Analysis

Once several ‘strong analytic directions’ (Charmaz, 2006) had been generated from line-by-line coding and sorting, focused coding was used to elaborate codes and explicate relationships between them with the constant comparative method used throughout the analysis (Charmaz, 2006; Glaser & Strauss, 1967). Where participants deviated from the emerging theory (i.e. negative cases), analysis was re-scrutinised and refined. As the analysis culminated into a more abstract understanding of participants’ experiences, part of the process model was presented to the last two interviewees for consideration. Interviews were discontinued once theoretical sufficiency had been achieved.

Quality

Transparency and systematicity, with ‘any deviations described and justified’ (Meyrick, 2006, p. 803), were sought throughout to address issues of rigour and quality. Independent coding of transcript excerpts also occurred, in addition to debriefing with peers, to ensure that there was sufficient agreement regarding the emerging codes and model.

Findings

The core category, ‘A Question of Attribution’, characterised all 14 accounts. The term was used to reflect the way in which participants explored causality in relation to ISB exhibited by older adults with a dementia. Four main categories were inducted: ‘Beyond My Construing’, ‘Contextualising’, ‘Interpreting’ and ‘Dealing With’. The main and major categories are displayed in Table 1 and will be conveyed below.
Beyond My Construing

‘Beyond My Construing’ represented participants’ initial experience of ISB exhibited by older adults with a dementia, although was not confined to first encounters alone. Feelings of shock and embarrassment appeared prominent, with a minority expressing that the shock did not arise because ISB was unexpected, rather it related to a belief that it would not be personally experienced. Participants also described a sense of incomprehension in knowing how to respond to ISB, which changed with repeated experience.

...I was quite young as well, probably quite embarrassed...not really knowing what to do...Do you mm do you say, ‘don’t say that’ or do you say ‘ignore it’ or... (Rachel)

Generally, participants expected to experience challenging behaviour, although many felt unprepared for ISB.

...I didn’t expect it [ISB], I guess. Um, I kind of understood and expected that there’d be challenging behaviour in terms of aggression...(Grace)

Some participants had never anticipated ISB with the client group because it felt age-inappropriate.

You know, you’d expect, well I would expect, a younger person, maybe. Hormones going mad when you’re young. yeah? (Dennis)

Most participants did not consider that the age of the patient was relevant in experiencing and interpreting ISB. However, a small minority struggled with notions that older adults were sexually active, particularly where older patients were widowed and without a sexual partner. ‘Assuming heterosexuality’ was reported to pervade the hospital and radiated beyond interpretations of ISB into realms of patient sexuality, sexuality and older adults’

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Table 1. Main and major categories

| Main category       | Major categories                                    |
|---------------------|-----------------------------------------------------|
| Beyond My Construing| Being shocked & embarrassed                         |
|                     | Incomprehending                                     |
|                     | Loosening expectations                              |
| Contextualising     | Defining behaviours                                 |
|                     | ‘That’s dementia’                                    |
|                     | Knowing patients                                    |
|                     | Upholding social norms                              |
|                     | Holding the whole person in mind                    |
| Interpreting        | Assessing capacity                                  |
|                     | Feeling towards                                     |
|                     | Reflecting                                           |
| Dealing With        | Minimising                                          |
|                     | Being risk aware                                    |
|                     | Managing boundaries                                  |
|                     | Doing your best                                     |

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and participants’ own sexuality. Perceived homosexual acts were construed as more unsettling.

... I just think from another male, um, it’s just (.) different, er, a male displaying some sexually inappropriate behaviour. It was quite (.) sort of difficult to deal with. I’m not a homophobic in the slightest but there was just something more uncomfortable. (Mike)

**Contextualising**

‘Contextualising’ related to the ways in which participants used different contexts to understand their experiences; by attending to the behaviour itself, using their knowledge of dementia and of the individual patient. Some described wider contextual and less explicit influences that were termed ‘holding the whole person in mind’ and ‘upholding social norms’.

Participants reported experiencing a range of ISB from subtle innuendoes to overt behaviours, such as groping, with these latter acts being more explicit and definite. The type, severity and frequency of the ISB enabled participants to define the behaviour and their response. Environment appeared vital during this process and participants questioned inappropriateness, especially in relation to personal care routines in which behaviours could be exculpated.

I’m not saying what they are doing is right but sometimes you can (...) excuse what they’re doing because sometimes you are putting them in a situation where they are exposed. (Anna)

Participants conveyed the importance of assessing the possible function of ISB rather than assuming that it intimated arousal, and staff perceptions of intent seemed to be mediated by subjective feelings towards and tolerance of certain behaviours:

... a verbal comment to me might seem very trivial but to somebody else it, you know obviously it, it can differ immensely. (Kate)

In contrast to their constructions of ISB, staff who acknowledged more frequent exposure to aggression presented the latter as more tangible, acceptable to others and less personal. Some participants also described feeling more uncomfortable, unsettled and exposed in relation to ISB:

I’d feel more comfortable going to the ward manager and going ‘oh my God I’ve been punched in the face’ with my face bleeding than going to the manager [laughs] and saying ‘I’ve just had my crotch (...) squeezed... the aggression’s almost more, I don’t know (.) obvious and blatant and in your face... (Grace)

...when it’s actually (.) sexualised it’s almost, you feel a bit like it’s more direct and... I don’t know what it is but I find it much more unnerving than (.) being, being called a, a nasty name. (Sam)

‘That’s Dementia’ (in vivo code) related to the process of contextualising the ISB within and as a consequence of the illness. This was facilitated by having knowledge of dementia through training, self-education and experience, and strengthened with time and exposure.

... I weigh up the sort of pathology of the patients to sort of... rationalise it and, you know, not try and let it get too personal... you’re able to rationalise it and see that it’s a, an (.) an evident part of their illness, their disinhibition. (Mike)
Knowing about the past lives of patients facilitated definition, attribution and anticipation of behaviours (fundamental to risk awareness) and assisted intervention. However, knowing patients was not always possible, given insufficient and inconsistent recording (with staff construing behaviours as safety-seeking and failing to document them) or not having access to patient history. Communication difficulties and lack of reciprocity with those patients perceived as ‘more advanced’ were also cited, which affected intervention.

... the ones that I build up more of a, er, er, like a relationship with... I think it’s easier to, to deal with, you know... (Dennis)

‘Holding the whole person in mind’ referred to the way in which staff attempted to keep the whole person in mind whilst contextualising ISB, a process that was characterised by narratives of integration and fragmentation. Participants described trying to maintain the humanity, dignity and sexuality of patients through a process of empathy, sympathy and, for some, an awareness of their own mortality.

... I think I just try to look at the whole person. Try and keep their dignity intact... (Kate)
... at the end of the day they are human, the same as us and they do have needs... (Anna)

For staff, keeping the whole patient in mind appeared to be affected by perceived capacity; the less aware patients were perceived to be, the more fragmented they were regarded. Separating the ISB from the patient occurred through a process of desexualising and diminishing and when sexualised behaviours were exhibited by patients without awareness, this was generally regarded as a ‘misfiring of the brain’.

... you felt sorry for him because you thought... he doesn’t know what he’s saying... He’s not being sexual. Well, he is, the words are but his intention isn’t there, not really... (Helen)

Generally, ISB was associated with male patients. Female staff, especially younger females, seemed more likely to be the recipient of ISB compared to male colleagues and there appeared to be a qualitative difference in the way ISB exhibited by male and female patients was perceived, especially when patients were regarded as ‘early stage’.

... usually if it’s a man it’s always seen as sexual, if it’s woman it isn’t... they give like an allowance [for females] of what’s expected or what’s not. (Christopher)

This ‘allowance’ seemed to relate to behaviours being seen as ‘flirtatious’ or ‘friendly’ rather than being sexually inappropriate.

... I’m not saying that’s how I think but she’s a woman, she’s harmless, she’s not going to do anything... it’s just flirting, I think. Where do you think that comes from? I think that’s just social norms, to be honest. I think if a woman flirts it’s harmless, if a man flirts he [laughs]... he’s up to something, you know, he’s not just flirting... (Sam)

These differences also resonated with participants’ own gender. Male participants tended not to see themselves as a target for ISB, whereas female staff seemed to anticipate ISB exhibited by male patients yet be desensitised to ISB exhibited by female patients.

I’m thinking of another patient at the moment that I go and see now who’s (.) who has this very penetrating look... it has sort of those sexual overtones... I mean as a woman you are aware of things like that. (Julie)
Interpreting

Participants attempted to make sense of ISB, with recourse to cognitive, emotional and socially driven processes. Many participants speculated about patient intention and awareness, shaped by their knowledge of the individual and dementia with a clear differentiation between early and later stage dementia.

ISB exhibited by ‘patients in the earlier stages’ was generally considered sexual, intentional and within control, whereas ISB exhibited by ‘patients in the later stages’ was desexualised because patients were generally seen as unaware. Explorations of how early and later stage dementia was identified revealed that participants predominantly used physical indicators, such as mobility and continence.

Patients construed as lacking capacity were generally regarded as blameless. However, if patients’ behaviour was construed as intentional and could be voluntarily extinguished, this seemed to generate anger and diminished sympathy:

...there was a lot of anger at the time because um (...) a lot of staff thought that er (...) this particular patient was just doing it for attention... (Rachel)

Equivocal feelings appeared common, with some participants reporting indifference, others feeling exposed and violated. Those who reported apathy towards ISB contextualised it in the dementia diagnosis, although all participants reported discomfort at some point, especially regarding earlier experiences. Participants’ explanations for their apparent indifference included minimisation of the type of ISB, having a ‘thick skin’ and limited experience.

In contrast to indifference, feelings of awkwardness, disturbance and upset were experienced by some participants with a minority experiencing anger.

...I just felt like a, you know, just [laughs] a bit sort of dirty really... I felt like I must go and have a shower... felt quite unsettling, yeah I must admit that one was really (...) really difficult to deal with. (Mike)

A minority of participants, including those generally indifferent towards ISB, questioned themselves. Specifically, they grappled with the question of whether or not they had ‘led the patient on’.

...it made me question whether I’d done something to encourage it...I suddenly sort of looked back and thought, well I did use to, you know, go up to him and, and talk to him perhaps more than other patients...so I suddenly thought oh God I hope that I haven’t done anything to make him think that I’m having a relationship with him. (Grace)

Despite participants reportedly feeling comfortable discussing ISB and issues around sexuality, this felt questionable. Their use of laughter, silence and whispering of responses suggested possible unease.

He was sitting facing me (...) and he started exposing himself and masturbating in the lounge [Beth says ‘masturbating in the lounge’ quietly]. (Beth)

Participants processed their experience(s) of ISB using intra and interpersonal reflection. Consulting peers who knew the patient was described as adequate and supportive, although for a minority ISB remained a taboo and experience was not shared. Disclosing experiences
assisted staff with formulation and intervention, their awareness of potential prejudices and reduced a sense of isolation.

We make judgements all the time. We’re, it’s what humans do… but it’s being conscious of that… You have to be honest which is kind of what I think of with the MDT, coming back to the ward round, we’re able to do that, in a way. (Neil)

A minority of participants felt less able to seek support. Solitary reflection seemed to result from a lack of opportunity or forum for discussion with others and the relative infrequency of ISB. Very few people participants reported having regular access to clinical supervision and, for some, anticipating a negative response from colleagues prevented them sharing their experiences.

**Dealing With**

You know we just deal with it. (Beth)

Participants ‘dealt with’ ISB through the conventions of care planning and risk assessment, although at times interventions appeared reactive and ad hoc. ‘Dealing With’ was also adopted to convey the general tone with which participants talked about responding to ISB, which was often blunt and lacking affect.

Participants described a process of minimising ISB that developed over time and this seemed to relate to knowing patients, assessing capacity and feelings of indifference. Minimising occurred in three foremost ways: ‘habituating’, ‘exculpating patients’ and ‘adapting with age’. With repeated exposure, participants described ‘getting used to’ and being ‘immune’ to ISB, which was seen to protect staff, although some participants reported concern that habituating could foster a blaseé attitude, endangering both staff and patients, linking to ‘being risk aware’.

…you can just get used to it really. You know, a lot different patients mm over the years and a lot of it’s cause of their illness more than anything else. (Eileen)

Exculpating patients predominately occurred when ISB was perceived as uncontrollable. Exculpating did not mean the behaviour was seen as acceptable, although many acknowledged that it could be an aspect of a patient’s presentation.

…as patients decline (.) staff (...) think, ‘oh well they can’t help it’ whereas… to begin with it’s like (.) almost like a personal…I think people take it very personally’. (Rachel)

‘Adapting with age’ emerged from conversations with female participants who defined themselves as ‘older’. These participants felt that dealing with ISB evolved with age. In addition to having more transferable life experiences, participants viewed themselves as more accepting of life in general, more self-aware, more willing to talk about sex and possessing enhanced coping mechanisms that supported their response to ISB compared to younger colleagues, although this was not unanimous.

…I suppose being older as well we get more comfortable in our own skin and more confident… (Beth)

…you get the jokes and the jests and the innuendos and over the years and the older you get you just take no notice. And I think I’ve brought that with me… maybe you sort of get a bit immune
and you think, ‘oh yeah’, you know ‘here we go again, another comment’. Whereas the younger ones...(Helen)

Participants said they were less likely to regard themselves as objects of desire, which possibly enabled a greater degree of indifference towards behaviours.

I think you feel you’re getting older and you’re no longer perhaps a sexual object. I don’t quite mean that Mm But, you (.) you know, you see your wrinkles on your face every morning and you, you know, do a Germaine Greer. You know, Germaine Greer said something about becoming a, a, um, invisible. (Julie)

Generally, commentaries from younger participants appeared to fit with reports from older colleagues, with younger participants reporting more discomfort. However, this did not necessarily relate to assertiveness. Younger participants compared the rapport between themselves and older patients to relationships with older male relatives.

I feel uncomfortable…they’re old enough as your father and stuff…(Anna)

‘Being risk aware’ was a predominant discourse within the hospital. Knowing which patients were likely to exhibit ISB and working in a risk-oriented context alerted participants to the possibility and associated consequences of ISB. At ward level, it ensured measures were introduced to protect staff and patients from harm, offence and accusation.

I’m certainly, um a lot more cautious with particular patients, er with that patient I’m, I’m more sort of risk aware…(Mike)

Protecting staff/patients also demanded consideration of patient wellbeing. For example, a minority of participants described the importance of male patients having access to female company:

…you’ve got to balance out if the patient, um, gets a lot from just female company…it’s a difficult one because obviously you’ve got to protect you, your staff but you’ve got to look out for the welfare of the patient. (Steve)

Some participants believed that older adults, especially those construed as having an advanced dementia, were less risky. This contrasted with experience of other patient groups, especially younger patients and for some had shaped their decision to enter into dementia care.

…I don’t see older adults with dementia as a threat…I feel quite safe (.) in being in between all the adults with dementia as far as sexual behaviour is concerned…(Christopher)

…when they’re younger (…) I think they would be more forceful anyway mm whereas with the elderly they’re a bit more gentle. (Eileen)

The use of touch was viewed as permissible in dementia care, because it enabled participants to engage with patients who might otherwise be ‘lost’ and disconnected. Some participants reported ambivalence within their staff teams regarding appropriateness of touch. When patients became disinhibited this was not always deemed proper and a
minority of participants raised their discomfort regarding ‘different boundaries for different patients’, which was felt to confuse patients.

...on the same ward they’ve got another patient who is allowed to touch and that patient is going to see it but he doesn’t know why or if he knows he forgets...(Christopher)

This process of ‘managing boundaries’ was noted as particularly difficult for some participants when patients mistook them for loved ones.

...it was very uncomfortable for me and I did feel, you know, really horrible, um(.) but also the patient must feel really awkward when you explain to them no, you’re not that person who you think I am. (Anna)

Physical distancing was used by participants who had been affected by their experience of ISB but appeared time-limited.

...I think I would kind of like(.) maybe not deal with that patient for the rest of the day and that’s maybe not a good way on how you deal with the situation...(Anna)

For one participant, however, the process of detachment was longer term.

...I had to separate myself from him yeah so it had an impact on our relationship...It was easier to detach myself and hear it from him than yes than(.) being very friendly with him and just having that rapport and then hearing it. (Sam)

Despite care planning, dealing with ISB was generally approached pragmatically. Whilst staff appreciated that a systematic method was desirable, it did not seem person-centred. Staff seemed to perceive a lack of dedicated training on management of ISB, which caused frustration. Tailored interventions were designed for patients exhibiting severe and persistent ISB, but for patients without formalised care plans, participants developed ways of dealing with ISB based on their knowledge of the patient and was facilitated by observing others, especially at the beginning of their careers.

...I think as you become more, um(...) knowledgeable about your patient group and individuals mm you, you kind of know how to deal with each situation as it arises with each patient. (Rachel)

...I don’t think I’ve had any formal training as such but you learn from other people and when they talk about things. (Julie)

Participants drew on previous experiences of responding to ISB in order to deal with it. This involved judging its appropriateness, reviewing previous work with the same patient, considering experience of similar behaviours within the hospital context and other work settings, and reflecting on personal experiences beyond work, such as experiencing ISB ‘out on a Friday night’.

You get more experience after..., after it happening every shift after a while. (Dennis)

ISB seemed to be construed and dealt with differently depending on ward ethos and related to ‘defining behaviours’, ‘assessing capacity’ and ‘being risk aware’. On the specialist dementia ward, ISB was seen as more likely to be minimised and clinical leadership was implicated as being influential.
...the staff on [specialist dementia ward] unless it’s really explicit and sometimes it is, would see it more as (.) just part of the care role. It’s much more a residential kind of feeling to it.

(Grace)

**Discussion**

A ‘Question of Attribution’ suffused all 14 interviews and referred to the way participants accounted for ISB exhibited by patients with a dementia. This was perhaps unsurprising, given that attribution seeks to understand how people experience, comprehend and predict the world by ascribing causation (Munton, Silvester, Stratton, & Hanks, 1999) and attribution theory is widely applied in other health settings (Noone, Jones, & Hastings, 2006; Weigel, Langdon, Collins, & O’ Brien, 2006).

Participants in this study described a myriad of intrapersonal, interpersonal (i.e. ‘reflecting’), conscious and less conscious processes (i.e. ‘upholding gender norms’) whilst making sense of ISB. Attribution of control featured prominently in ‘assessing capacity’. Participants largely attributed ISB to external factors, assuming uncontrollability, which are argued to promote sympathy and help-giving behaviours and are consistent with a cognition-emotion-behaviour model (Rudolph, Roesch, Greitmeyer, & Weiner, 2004). However, this was not necessarily the case. Despite making attributions of uncontrollability, some staff reported upset, distress and even anger, which for some undermined subsequent support/interventions. Furthermore, where patient behaviour was constructed by staff as under active patient control, staff emotional response varied between anger and conviviality.

Staff response to ISB revealed a temporal dimension to attribution absent from other findings (Rudolph et al., 2004). During early encounters with ISB (‘beyond my construing’) participants described less a sequence of experiences (‘shock and embarrassment’) rather an inability to understand (‘incomprehension’). With repeated exposure and increased context, participants gradually ascribed causation. Others have argued for a more circumscribed role for attributions. Todd and Watts (2005) in examining helping behaviour of staff working with older adults with dementia who exhibited challenging behaviour, suggested that the care role supersedes beliefs about causation; this seems supported by other research (Fopma-Loy & Austin, 1997; Werner, Cohen-Mansfield, & Newman, 1999). This may explain the propensity for participants to ‘minimise’ and ‘deal with’ ISB.

Emerging in this study was the diminishing power of attributions to shape staff response as contextual information increased (Todd & Watts, 2005). Participants referred to various contexts to understand their experiences, including the behaviour itself and their knowledge of dementia and of the patient. Some participants also described wider contextual influences, for example, gender. The contextualising of this challenging behaviour can facilitate understanding and support patient–staff relationships (Edberg et al., 2008; Kovac, Noonan, Schildt, & Wells, 2005), enhancing job retention (Sung, Chang, & Tsai, 2005).

Making sense of ISB involved cognitive, emotional and socially driven processes, none of which have been adequately captured in the current literature (Knight et al., 2008). Many participants felt that patients with earlier stage dementia were more aware and in control of their actions, although research suggests that this period of the illness can generate disablement and fear (Steeman, Dierckx de Casterle, Godderis, & Grypdonck, 2005), which was not referred to with the exception of recognising potential embarrassment. Participants who differentiated between earlier and later stage dementia used physical
indicators, such as mobility and continence. No participant discussed formal capacity assessment but most did communicate behaviour to the wider team, which may have included formal appraisal, although decisions were not made transparent during interviews.

Factors such as type, frequency, severity and environment seemed to define behaviour as appropriately or inappropriately sexual. Judgement was problematic, appearing to reflect the wider, evolving debates about clarifying ISB (Johnson et al., 2006; Knight et al., 2008) complicated by wider and ambiguous social and political contexts regarding what is sexually inappropriate.

Mindful of Kitwood’s (1997) injunction to address ‘malignant social psychology’, participants in this study objectified patients to some degree whilst contextualising and interpreting ISB, as highlighted by the assumption that people with advanced dementia lacked awareness and intentionality, or loss of selfhood. However, the process of fragmentation, whereby participants separated the behaviour from the patient seemed to relate to staff reconciling the ISB. The dignity and sexuality of the whole person appeared maintained through a process of contextualisation, empathy and, for some, recognition of their own humanity and sexuality. It is not known how this oscillation between separation and integration affected rehabilitation in the study, which is often compromised by fragmentary rhetoric (Dewing, 2003), although staff negatively constructed attempts to distance the self from patients after experiencing an incident.

Patient gender was believed to shape staff perceptions of ISB; behaviours were more likely to be construed as ISB if exhibited by a male rather than a female. Underreporting inappropriate behaviour exhibited by female psychiatric patients (Skeem et al., 2005) is often overlooked, as is female sexual expression, with women repeatedly construed as vulnerable (Hughes & Hebb, 2005; Ward, Vaas, Aggarwal, Garfield, & Cybyk, 2005). Skeem et al. (2005) suggested that underreporting occurred because males are generally more overtly violent. Data from the hospital in which this study was situated suggested that the majority of ISB recordings were male related, supporting this analysis. However, the findings from this study suggest that mere frequency is not a complete explanation.

‘Pathologising’ male sexual behaviour whilst rendering female sexuality ‘invisible’ through constructions of vulnerability is consistent with the wider literature (Ward et al., 2005). Differences in gender constructions can be traced back to the Ancients. The Greek nouns ‘aphrodisiazein’ and ‘aphrodisiasthenai’ correspond to the active (masculine) and passive (feminine) roles in sexual intercourse (Aristotle, cited in Foucault, 1984). Each have their distinct functions, ‘the one who performs the activity and the one on whom it is performed’ (Foucault, 1984, p. 47), which may also be underpinned by the overt versus inverted sexual anatomy of males and females, respectively. Such polarities seem to correspond with findings from this study. Ward et al. (2005) termed this a ‘gendered dichotomy’, which they suggested is also influenced by environment. It is of note that the majority of staff at the hospital were female and most of the patients male; further analysis of gendered interactions might be warranted.

Generally, participants felt that ISB did not affect them, consistent with other findings (Cubit et al., 2007; Matsuoka et al., 2003). However, all participants reported discomfort and, for some, feelings of distress were intense. A ‘tension’ generated by ‘behaviours of concern’ has been reported in other studies (Cubit et al., 2007), with participants reporting distress yet simultaneously demonstrating ‘empathic acceptance’. The authors reasoned that this communicated a sufficient knowledge base of dementia or that staff
‘objectified’ behaviours that essentially stopped staff from formulating problematic behaviours. Similarly, participants in this study both experienced distress yet contextualised and minimised ISB. However, most did not describe disengagement from the process of understanding. Propositions regarding sexual urge/expression, temperature and communication amongst others were actively considered. Furthermore, most participants did not experience ISB as acceptable, rather they accepted it as part of patient presentation. Rather than the dichotomising suggested by Cubit and colleagues, these findings suggest that minimisation may be an integrated means of protecting staff, allowing them to fulfil their duties.

It is important to recognise staff’s emotional response to behaviours exhibited by patients of the same sex, which has been identified as a major issue for men. The psychological impact of sexual assault on males is often underestimated and services can be unknowing and insensitive to male victims (Ainscough & Toon, 1993; Davies, 2002). Although ISB experienced by staff within the context of this research is different to sexual assault that, for example, occurs during dating (Davies, 2002), the effect on staff could be overlooked because of heterosexist assumptions. Despite contextualising his experience in the dementia, one participant recounted feeling ‘violated’ and ‘feeling a need to shower’. His explanation for not seeking support was that colleagues would think him over-reactive.

Female participants felt that their methods of dealing with ISB evolved with age, relating to cumulative transferable life experiences and increased self-awareness. The influence of age on response has been noted in relation to aggression and sexual expression and linked with experience (Bouman, Arcelus, & Benbow, 2007; Cubit et al., 2007; Nakahira, Moyle, Creedy, & Hitomi, 2008; Ward et al., 2005). However, studies fail to adequately comment about age and, furthermore, do not provide clear information regarding gender. The women in this study seemed to suggest that being regarded as a sexual being diminished with age. Subsequently ISB was construed less threateningly and excused, possibly underpinned by societal attitudes towards female sexuality and aging (Ward et al., 2005).

**Critique**

Quality checks, such as prolonged engagement with the material and peer debriefing, along with a systematic and transparent approach argue for a model that is credible, trustworthy and grounded (Meyrick, 2006). However the research could be further strengthened.

Although 14 participants were deemed adequate for ‘theoretical sufficiency’ (Dey, 1999, as cited in Charmaz, 2006), further interviews may have yielded new data or interpretations that would have extended and refined the model. Participants were all self-selecting and arguably motivated and confident enough to discuss their experiences. Given the sensitive nature of ISB, an alternative methodology, such as a diary study, might have encouraged other people to share experiences that would develop this account.

Participants primarily drew from their experiences working within a specialist in-patient setting familiar with ISB, which had recently adopted a recording tool to capture the phenomena. ISB may thus be artefact of the environment and findings may be context specific. Nevertheless, despite specialist dementia training implemented at this hospital, ISB remained a source of concern for a significant number of staff, with clear and negative ramifications for their wellbeing and that of patients. Undertaking the study in
this context permitted a previously under-researched and taboo topic to be addressed with more rigour.

**Clinical implications**

As new staff enter post, information emphasising challenging behaviours can be unsettling (Robinson & Cubit, 2007). Yet findings suggest a need for explicit training regarding ISB. The provision of adequate and embedded support structures for staff through supervision, peer support and more ad hoc provision appears needed to acknowledge and more systematically address distress engendered in the context of ISB This may be of particular value to trainees/students, who have less long-term investment in working with older adults and may not be able to gain a temporal perspective available to those who work over a longer period. Providing adequate context to staff less familiar with dementia care and/or individual patients should be given, as this appears instrumental to understanding and managing ISB (Todd & Watts, 2005). Lastly, facilitation of appropriate staff attributions, which can mitigate distress and enhance care, may be helped by staff’s increased understanding of the psychological impact of earlier and later stage dementia.

**Further research**

As an increasing focus on supporting and maintaining people with a dementia within their own environment evolves, services will need to consider the experiences of family caregivers. ISBs are known to cause embarrassment, leading to isolation and reluctance to accept social support (Robinson, 2003). The impact of ISB on family caregivers has not been explored in depth, which further research could address.

Despite some participants indicating significant variation in how ISB was perceived within cultures others than White British, the category ‘Culture’ lacked theoretical sufficiency. Anthropological studies have illuminated cultural variations in perceptions of aging and mental health, including dementia (Dein & Huline-Dickens, 1997), revealing cultural differences towards sex and intimacy, with potential to affect patient care (Boggatz & Dassen, 2006). For example, Chinese nurses associate male genital-related care with sex, and given the Chinese culture of ‘sexual conservativeness’ some nurses were averse to carrying out personal hygiene duties, thus, neglecting care (Zang, Chung, & Wong, 2008). Further research could sample minority groups to explicate this.

The impact of ISB upon other patients was less of a focus in this study, yet research has shown that in-patients are not passive observers. In-patients engage various strategies, such as de-escalation, when feeling under threat (Quirk, Lelliott, & Seale, 2005). A future study might explore the impact of ISB on fellow patients/residents.

Canvassing responses using a questionnaire design based on this research could be developed to recruit a broader audience (i.e. family caregivers and residential). This may utilise additional forms of data collection, such as diaries or focus groups.

**Conclusion**

Whilst previous research has focused on defining ISB and ascertaining prevalence in patients with neuropsychological impairments (Guay, 2008; Knight et al., 2008), an exploration of the psycho-social processes involved whilst working in dementia care and, in particular, a
fuller understanding of the psychological and emotional impact ISB has on staff has been overlooked. This research responded to that need and uncovered a range and complexity of experience that provides a framework for understanding staff experiences of ISB within in-patients settings.

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